Virginia FY 2016
Preventive Health and Health Services Block Grant

DRAFT Work Plan

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Executive Summary

This work plan is for the Preventive Health and Health Services (PHHS) Block Grant for Federal Year 2016. It is submitted by the Virginia Department of Health as the designated state agency for the allocation and administration of PHHSBG funds.

Funding Assumptions: The total award for the FY 2016 Preventive Health and Health Services Block Grant is $TBD. This amount is based on the FY2016 allocation table TO BE distributed by the Centers for Disease Control and Prevention. Of the total amount, $187,765 has been allocated for administrative costs to cover salary and related expenses, phone charges, and IT functions. FY2016 funds are allocated to programs in priority health areas that address the following Healthy People 2020 national health status objectives:

(HO IVP – 1) Fatal and Nonfatal Injuries: $238,100 of this total will support the Injury and Violence Prevention Program, which will provide resources, technical assistance and training to build and maintain a statewide injury prevention infrastructure.

(HO IVP – 2) Traumatic Brain Injury: $108,733 of this total will support the Traumatic Brain Injury Prevention Program. Funds will support the provision of training, education, resources and technical assistance that will address traumatic brain injuries related to youth bicycle safety and school athletics.

(HO IVP – 9) Poisoning Deaths: $151,969 will be used to support the Prescription Drug Prevention Program, which will provide training, education and resources for the prevention of prescription drug misuse and abuse.

(HO IVP – 40) Sexual Assault-Rape Crisis: $178,896 of this total is a mandatory allocation to address the prevention of sexual assaults. The Virginia Department of Health contracts with the Virginia Sexual and Domestic Violence Action Alliance to provide statewide coordination of sexual assault advocacy, data collection on victim services and outcomes, technical assistance, and training to local sexual assault crisis centers and other professionals.

(HO NWS – 9) Obesity in Adults: $648,703 of this total will be used to fund the Building Healthy Communities Program. Funds will be used to support both the sustainability and implementation of evidence-based obesity prevention programs in local health districts.

(HO OH – 7) Use of Oral Health Care System: $59,104 of this total will be to support the Oral Health Care Access for Children with Special Health Care Needs (CSHNC) Program. Funds will provide education and training to dentists in an effort to encourage increased care or children with special health care needs.

(HO OH – 13) Community Water Fluoridation: $175,000 of this total will be used to maintain Virginia’s optimal community water fluoridation level. Funds will be used to support the Community Water Fluoridation Program's coordinator position and for equipment upgrades, monitoring water systems, and providing training, education, and technical assistance.

(HO OH – 16) Oral and Craniofacial State-Based Health Surveillance System: $20,190 of this total will be used to conduct a basic screening survey of children enrolled in Virginia’s Head Start Program. $81,276 will be used to conduct an oral health assessment of Virginia’s elderly population.

(HO PHI – 7) National Data for Healthy People 2020 Objectives: $476,749 of this total will be used to increase the sample size of the Behavioral Risk Factor Surveillance System. $65,100 of this total will be used to support staff and activities of the Pregnancy Risk Assessment Monitoring System. $117,818 will be used to support staff, activities and data provision for the Youth Risk Behavior Survey.

(HO PHI – 14) Public Health System Assessment: $581,622 of this total will be utilized to support the Centralized Support for Community Health Assessments initiative. Funds will support staff within the

Division of Policy and Evaluation who will provide support to each of the 35 local health districts in conducting community needs assessments and community health improvement plans.

Funding Priority: Under or Unfunded

Budget Detail for VA 2016 V0 R0	
Total Award (1+6)	$3,091,025
A. Current Year Annual Basic	
1. Annual Basic Amount	$2,912,129
2. Annual Basic Admin Cost	($187,765)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$2,724,364
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$178,896
7. Sex Offense Admin Cost	$0
(8.) Sub-Total Sex Offense Set Aside	$178,896
(9.) Total Current Year Available Amount (5+8)	$2,903,260
C. Prior Year Dollars	
10. Annual Basic	$0
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$0
13. Total Available for Allocation (5+8+12)	$2,903,260

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$2,724,364
Sex Offense Set Aside	$178,896
Available Current Year PHHSBG Dollars	$2,903,260
B. PHHSBG $'s Prior Year:	
Annual Basic	$0
Sex Offense Set Aside	$0
Available Prior Year PHHSBG Dollars	$0
C. Total Funds Available for Allocation	$2,903,260

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
Building Healthy Communities	NWS-9 Obesity in Adults	$648,703	$0	$648,703
Sub-Total		**$648,703**	**$0**	**$648,703**
Centralized Support for Community Health Assessments and Improvement Plans	PHI-14 Public Health System Assessment	$581,622	$0	$581,622
Sub-Total		**$581,622**	**$0**	**$581,622**
Community Water Fluoridation	OH-13 Community Water Fluoridation	$175,000	$0	$175,000
Sub-Total		**$175,000**	**$0**	**$175,000**
Head Start Dental Data Collection	OH-16 Oral and Craniofacial State-Based Health Surveillance System	$20,190	$0	$20,190
Sub-Total		**$20,190**	**$0**	**$20,190**
Injury and Violence Prevention Program	IVP-1 Total Injury	$238,100	$0	$238,100
Sub-Total		**$238,100**	**$0**	**$238,100**
OFHS Program Support – Behavioral Risk Factor Surveillance System (BRFSS)	PHI-14 Public Health System Assessment	$476,749	$0	$476,749
Sub-Total		**$476,749**	**$0**	**$476,749**
OFHS Program Support – Pregnancy Risk Assessment Monitoring System (PRAMS)	PHI-7 National Data for Healthy People 2020 Objectives	$65,100	$0	$65,100
Sub-Total		**$65,100**	**$0**	**$65,100**
OFHS Program Support – Youth Risk Behavior Survey (YRBS) and School Health Profiles (SHP)	PHI-7 National Data for Healthy People 2020 Objectives	$117,818	$0	$117,818
Sub-Total		**$117,818**	**$0**	**$117,818**
Oral Health Assessment of Virginia's Elders	OH-16 Oral and Craniofacial State-Based Health Surveillance System	$81,276	$0	$81,276
Sub-Total		**$81,276**	**$0**	**$81,276**
Oral Health Care Access for Children with Special Health Care Needs	OH-7 Use of Oral Health Care System	$59,104	$0	$59,104

(CSHCN)				
Sub-Total		**$59,104**	**$0**	**$59,104**
Prescription Drug Prevention Program	IVP-9 Poisoning Deaths	$151,969	$0	$151,969
Sub-Total		**$151,969**	**$0**	**$151,969**
Sexual Assault Intervention and Education Program	IVP-40 Sexual Violence (Rape Prevention)	$178,896	$0	$178,896
Sub-Total		**$178,896**	**$0**	**$178,896**
Traumatic Brain Injury Prevention Program	IVP-2 Traumatic Brain Injury	$108,733	$0	$108,733
Sub-Total		**$108,733**	**$0**	**$108,733**
Grand Total		**$2,903,260**	**$0**	**$2,903,260**

State Program Title: Building Healthy Communities

State Program Strategy:

Program Goal:
The program goal is to prevent obesity and other chronic diseases by providing Virginians information, tools and resources for promoting healthy nutrition and access to healthy eating options, and encouraging and reinforcing healthy and active lifestyles and behaviors. The program promotes evidence-based strategies, systems and environmental changes, and develops partnerships with businesses, public institutions, faith-based organizations and other entities to coordinate state-wide efforts and resources. Communities work to achieve the goal by promoting healthy food choices and physical activity, fostering supportive systems and environments for healthy behaviors, and developing partnerships, community-led interventions and programs, and consistent health messages.

Program Health Priority:
Chronic diseases – such as heart disease, stroke, cancer, and diabetes – are among the most prevalent, costly, and preventable of all health problems. Leading a healthy lifestyle (avoiding tobacco use, being physically active, and eating well) greatly reduces a person's risk for developing a chronic disease. Reversing the growing trends in obesity and reducing chronic diseases requires a comprehensive and coordinated approach that uses systems and environmental change strategies to transform communities into places that support and promote healthy lifestyle choices for all residents. Community initiatives must address environmental and system factors (including increasing access to healthier foods and creating easier access to safe places to exercise) that contribute to unhealthy lifestyles. The PHHS Block Grant provides funding, training, and technical assistance to aid communities in developing, delivering and evaluating evidence-based health promotion strategies and programs.

Primary Strategic Partners:
Intra-agency partnerships include the Cancer Prevention and Control Program; the Heart Disease and Stroke, Diabetes, Obesity and School Health Project (DP13-1305; DP14-1422); the Injury and Violence Prevention Program; the Tobacco Use Control Project; Child and Family Health Programs, the WIC Program; local health departments; and the Office of Minority Health and Health Equity.

State partners include the Virginia Departments of Education, Conservation and Recreation, Medical Assistance Services, Transportation and the Virginia Cooperative Extension.

External partners focused on the promotion of healthy lifestyles throughout Virginia include, but are not limited to the following: VA Farm to School Workgroup; VA Chapter of AAP Obesity Taskforce; the Virginia Chapter of American Academy of Family Physicians (VAFP), VA Association of Health, Physical Education, Recreation, and Dance (VAHPERD); VA Recreation and Park Society; Northern Virginia Healthy Kids Coalition, Virginia Association of School Nurses, Alliance for a Healthier Generation Healthcare Initiative; VA SRTS Network and VA Dietetic Association; YMCA; Virginia Business Coalition on Health; and Virginia Hospital and Healthcare Association.

Evaluation Methodology:
Surveillance data from the CDC Behavioral Risk Factor Surveillance System (BRFSS) will be used to evaluate program progress toward the overall goal of promoting healthy behaviors in Virginia communities. Additional data sources will be determined once intervention sites are selected.

State Program Setting:
Business, corporation or industry, Community based organization, Community health center, Faith based organization, Local health department, Schools or school district, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Vanessa Walker Harris
Position Title: DPHP Director
State-Level: 51% Local: 0% Other: 0% Total: 51%
Position Name: Kathy Rocco
Position Title: Chronic Disease Programs Manager
State-Level: 14% Local: 0% Other: 0% Total: 14%
Position Name: TBD
Position Title: PHHS Healthy Communities Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Henry Murdaugh
Position Title: Healthy Communities Supervisor
State-Level: 10% Local: 0% Other: 0% Total: 10%
Position Name: Sharon Jones
Position Title: Administrative Specialist
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 5
Total FTEs Funded: 2.75

National Health Objective: HO NWS-9 Obesity in Adults

State Health Objective(s):

Between 10/2014 and 09/2020, the Virginia Department of Health will reduce the percentage of adults who are overweight or obese from 64.7% to 63% by implementing evidence-based obesity and chronic disease prevention and control initiatives at the community level through agreements with VDH local health districts.

Between 10/2015 and 9/2020, the Virginia Department of Health will reduce the percentage of children who are overweight or obese from 26.7% to 24.5% by implementing evidence-based obesity and chronic disease prevention and control initiatives at the community level through agreements with VDH local health districts.

Baseline:
The adult obesity rate was 64.7% in 2014.

The child obesity rate was 26.7% in 2013 (percentage of high school students who were overweight or obese).

Data Source:
BRFSS, 2013 and 2014

State Health Problem:

Health Burden:
Obesity poses a major public health challenge. Each year nationwide, obesity contributes to an estimated 112,000 preventable deaths. Obese adults are at increased risk for many serious health conditions, including high blood pressure, high cholesterol, type 2 diabetes and its complications, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, and respiratory problems, as well as endometrial, breast, prostate, and colon cancers. Overweight and obesity rates in Virginia have increased significantly among adults and children over the last two decades. Compared nationally, Virginia currently ranks as the 32nd most obese state for adults (27.2%) and 24th for youth (12%).

In addition to increasing rates of overweight and obesity in Virginia, disparities continue to exist. When analyzed by race and ethnicity, 2013 BRFSS data reveals that 39.3% of black, Non-Hispanic Virginians and 22.5% of Hispanic Virginians are considered obese. When examining Virginia obesity trends by gender, data from 2013 indicates that over 27% of both males (27.1%) and females (27.3%) are considered obese.

The 2013 BRFSS revealed that only 51.2% of Virginia adults meet the recommendation for daily physical activity and over 25% reported no additional physical activity in the past month. The 2013 survey also revealed that only 17.8% of Virginia adults consume the recommended number of servings of fruits and vegetables daily.

Target Population:
Number: 8,001,024
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 238,842
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Other: Recommended Community Strategies & Measurements to Prevent Obesity in the United States (Centers for Disease Control and Prevention)
CDC Recommends: The Prevention Guidelines System (CDC)
Healthy People 2020
National Prevention Strategies
Virginia Chronic Disease Prevention and Health Promotion Collaborative Network's Shared Agenda

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $648,703
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $320,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

1. Implement programs

Between 10/2015 and 09/2016, VDH local health departments will increase the percent of Virginians who meet the recommendation for daily physical activity and who consume the recommended number of servings of fruit and vegetables daily from 51.2% (physical activity) and 17.8% (consumption) to **51.7% and 18%**.

Annual Activities:

1. Provide sustainability funding

Between 10/2015 and 09/2016, VDH will solicit sustainability work plans and budgets from the previous year PHHS-funded local health district recipients and establish a memorandum of understanding (MOU) agreement to be used to sustain coalitions and evidence-based obesity prevention activities already underway. Funding will be contingent on local health district providing peer mentoring to the newly selected local health districts.

2. Expand reach

Between 10/2015 and 09/2016, VDH will solicit proposals from and establish a memorandum of understanding (MOU) agreement with up to five additional VDH local health districts to implement evidence-based obesity prevention and lifestyle change initiatives at the community level. The newly funded local health districts will be matched with a mentor district based on established criteria.

3. Establish partnerships

Between 10/2015 and 09/2016, VDH local health districts will partner with local community coalitions and other multi-sectoral partners (including parks and recreation, transportation, housing, law enforcement, schools, academia, and county/city officials) to build and expand programs and ensure sustainability. Collaboration between local health districts and their local community coalitions will build sustainable policy, systems and environmental changes that will have a lasting impact on reducing obesity and chronic disease within the community.

4. Implement strategy

Between 10/2015 and 09/2016, VDH local health districts will work with their local community coalitions and partners to support and expand strategies identified in the *CDC Recommended Community Strategies & Measurements to Prevent Obesity in the United States* and align with the Virginia Shared Agenda (State chronic disease plan). Strategies to be implemented include the following:

- Obesity prevention coalition building;
- Improving access to outdoor recreational facilities;
- Increasing availability of healthier food and beverage choices in public service venues;
- Enhancing infrastructure supporting walking and bicycling;
- Improving availability of mechanisms for purchasing foods from farms; and
- Increasing opportunities for extracurricular physical activity.

VDH will provide technical assistance, resources, guidance, and monitor and evaluate progress.

State Program Title: Centralized Support for Community Health Assessments and Improvement Plans

State Program Strategy:

Program Goal:
The program goal is to provide systematic and centralized support to each of the 35 health districts to facilitate the completion of a community health assessment (CHA) and community health improvement plan (CHIP).

Program Health Priority:
The essential services of public health include policy development, assessment, and assurance. Community health assessments can be used to provide a picture of the health status of communities, to identify and prioritize areas of need, and to measure the impact of interventions undertaken to address these priorities. The Public Health Accreditation Board requires that local health departments complete a community health assessment and a community health improvement plan as a prerequisite to accreditation. Much of the data utilized for a community health assessment comes from secondary data sources, such as state and national surveys, vital statistics, and hospitalization data. This data can be more efficiently collected and aggregated centrally, rather than individually by each local health district.

Primary Strategic Partners:
Primary partners will include each of the 35 health districts, as well as other central offices and divisions in VDH, including, the Division of Prevention and Health Promotion, Office of Minority Health and Health Equity, Office of Epidemiology, Office of Environmental Health, and Office of Information Management. Additional partners may include local health systems, community organizations, and other constituents.

Evaluation Methodology:
The strategy effectiveness will be evaluated by assessing whether or not health districts are ready and have the capacity to conduct a CHA; the number of health metrics disseminated to local health districts; and an internal dashboard of 48 metrics for customized health district/county-level reporting.

State Program Setting:
Local health department, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Leslie Hoglund
Position Title: Population Health Manager
State-Level: 40% Local: 0% Other: 0% Total: 40%
Position Name: Danielle Henderson
Position Title: CHA Supervisor
State-Level: 65% Local: 0% Other: 0% Total: 65%
Position Name: Rebeka Sultana
Position Title: Epi Analyst
State-Level: 80% Local: 0% Other: 0% Total: 80%
Position Name: Janice Hicks
Position Title: Policy Analyst
State-Level: 48% Local: 0% Other: 0% Total: 48%
Position Name: TBD
Position Title: Policy Analyst
State-Level: 32% Local: 0% Other: 0% Total: 32%

Total Number of Positions Funded: 5
Total FTEs Funded: 2.65

National Health Objective: HO PHI-14 Public Health System Assessment

State Health Objective(s):

Between 10/2015 and 09/2016, VDH will assess the readiness of 35 local health districts to conduct a CHA and CHIP, provide technical assistance in carrying out CHA and CHIP approaches, and develop a dashboard for compiling and disseminating local data.

Baseline:
Central support began in 2015 with the development of an internal CHA workgroup to identify key indicators for an online dashboard for local data. Great disparity exists between the health districts regarding if and when they conduct CHAs, how often they are performed, and how they influence CHIP development and implementation.

Data Source:
Virginia Behavior Risk Factor Surveillance System, Virginia Online Injury Reporting System, Virginia Health Information, Virginia Vital Records

State Health Problem:

Health Burden:
Virginia has a population of approximately 8.2 million people who live in 134 localities that are organized into 35 different health districts and 5 health planning regions. The characteristics and the challenges in each of these districts, regions, and localities vary greatly, with significant differences in diabetes, obesity, smoking, and infant mortality. Capacity varies around the state in regards to a health district's ability to assess and report on the community's health status. Centralized support to complete a CHA and draft a CHIP will assure that each district engages with community stakeholders to identify those areas most relevant to the health of their community.

Target Population:
Number: 35
Infrastructure Groups: State and Local Health Departments, Other

Disparate Population:
Number: 35
Infrastructure Groups: State and Local Health Departments, Other

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: VDH will utilize best practices for community health assessments such as Mobilizing for Action through Planning and Partnerships (MAPP), as well as other tools that are available through the National Association of County and City Health Officials (NACCHO).

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $581,622
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

1. Assess CHA readiness

Between 10/2015 and 09/2016, VDH will conduct **35** assessments, one for each local health district, to determine readiness and capacity to conduct CHA and develop CHIP.

Annual Activities:

1. Assess readiness

Between 10/2015 and 09/2016, VDH will visit all 35 health districts to assess readiness and capacity to conduct CHA by June 30, 2016.

2. Publish CHIP process

Between 10/2015 and 06/2016, VDH will draft and publish CHIP process and resources for internal VDH website.

3. Begin CHA process

Between 10/2015 and 09/2016, VDH will engage all 35 health districts to begin CHA process (if they haven't already) and prompt CHIP development (by those with completed CHA).

Objective 2:

2. Develop dashboard

Between 10/2015 and 09/2016, VDH will develop **1** online dashboard of selected CHA metrics.

Annual Activities:

1. Collect data

Between 10/2015 and 03/2016, VDH will identify data sources and collect data on 48 selected indicators.

2. Visualize indicators

Between 10/2015 and 03/2016, VDH will aggregate and visualize indicators in Tableau dashboard.

3. Publish CHA website

Between 10/2015 and 06/2016, VDH will develop and publish website for customized CHA reporting by health districts.

4. Publish Plan for Well-being webpage

Between 10/2015 and 09/2016, VDH will develop and publish a Plan for Well-being webpage.

Objective 3:

3. Provide training and technical assistance

Between 10/2015 and 09/2016, VDH will provide training and technical assistance to **35** health districts on conducting CHA and CHIP.

Annual Activities:

1. Develop training module

Between 10/2015 and 06/2016, VDH will develop training module(s) on conducting CHA and developing CHIP.

State Program Title: Community Water Fluoridation

State Program Strategy:

Program Goal:
Virginia has met and exceeded the 2020 objective for Community Water Fluoridation (CWF) with 95.62% of Virginians who are served by community water systems receiving optimally fluoridated water. National health objectives call for 79.6 % of the U.S. population served by community water systems to be drinking optimally fluoridated water by 2020. Because of this success, the goal of the Community Water Fluoridation Program is to maintain the number of Virginia's citizens served by optimal community water fluoridation. Community water fluoridation is defined as adjusting and monitoring fluoride to reach optimal concentrations in community drinking water.

Program Health Priority:
Priorities for the program are to ensure safe and effective adjustment of community water to provide optimal fluoridation to reduce dental disease rates by monitoring water systems for compliance to rigorous standards. A public health strategy is to promote community water fluoridation through funding to initiate fluoridation or replace outdated fluoridation equipment.

Primary Strategic Partners:
Primary strategic partnerships for the CWF Program include the Virginia Department of Health's Office of Drinking Water (ODW) and associated regional field offices, Virginia Rural Water Association, Virginia Dental Association, American Academy of Pediatrics, Virginia Oral Health Coalition, and local governments.

Evaluation Methodology:
Evaluation methodology for the CWF program includes monitoring fluoridated water systems by reviewing monthly fluoridation operational reports and inspection surveys of water treatment plants; collecting, interpreting, and compiling monthly fluoride operational reports of all fluoridated water systems, and exporting the data to the Centers for Disease Control and Prevention (CDC) Water Fluoridation Monitoring System (WRFS); and conducting reviews with Office of Drinking Water on funded localities.

State Program Setting:
Other: Localities throughout the state

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: TBD
Position Title: Community Water Fluoridation Coordinator
State-Level: 75% Local: 0% Other: 0% Total: 75%

Total Number of Positions Funded: 1
Total FTEs Funded: 0.75

National Health Objective: HO OH-13 Community Water Fluoridation

State Health Objective(s):
Between 10/2015 and 09/2016, VDH will continue to provide optimally fluoridated water to 95% of Virginians who are served by community water systems.

Baseline:
Currently, 95% of Virginians on community water systems receive fluoridated water.

Data Source:
CDC Water Fluoridation Reporting System (WFRS) is a water fluoridation monitoring data system for state and tribal water fluoridation program managers. Data from WFRS are summarized in the biennial report of national and state fluoridation statistics. US Census population estimates are also used. The Annual Virginia Summary Data is maintained in WFRS serves as the data source for Virginia population receiving service from public water systems. Evidence Based Guidelines: Best Practice Criteria for CWF programs as recommended by the Association of State and Territorial Dental Directors

State Health Problem:

Health Burden:
Tooth decay affects more than one-fourth of U.S. children aged 2–5 years and half of those aged 12–15 years. About half of all children and two-thirds of adolescents aged 12–19 years from lower-income families have had decay. Children and adolescents of some racial and ethnic groups and those from lower-income families have more untreated tooth decay. For example, 40% of Mexican American children aged 6–8 years have untreated decay, compared with 25% of non-Hispanic whites. Among all adolescents aged 12–19 years, 20% currently have untreated decay. Tooth decay is also a problem for many adults, and adults and children of some racial and ethnic groups experience more untreated decay. According to the CDC, "Fluoridation safely and inexpensively benefits both children and adults by effectively preventing tooth decay, regardless of socioeconomic status or access to care."

Target Population:
Number: 6,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Best Practice Criteria for CWF programs as recommended by the Association of State and Territorial Dental Directors include:

Effectiveness: The effectiveness of community water fluoridation in preventing dental caries has been established by extensive research. Other measures for effective CWF programs include: compare the percentage of population served by public water systems with optimally fluoridated water to Healthy People 2010 objective; document the number of communities or public water systems with optimally fluoridated water and document the percent of fluoridated systems consistently maintaining optimal levels of fluoride (documentation of monthly monitoring consistent with CDC's fluoride reporting system).

Sustainability: Demonstrate sustainability through the number of years that identifiable water fluoridation program at state level has operated and the number of systems initiating, continuing, or discontinuing water fluoridation annually.

Collaboration: Demonstrate partnerships/coalitions with key stakeholders and organizations.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $175,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $117,500
Funds to Local Entities: $117,500
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Staff CWF coordinator position
Between 10/2015 and 09/2016, Dental Health Program staff will obtain **1** knowledgeable Community Water Fluoridation Program coordinator through the VDH recruitment and hiring process.

Annual Activities:
1. Complete recruitment paperwork
Between 10/2015 and 11/2015, Dental Health Program staff will complete paperwork for hiring and recruitment.

2. Complete position recruitment
Between 10/2015 and 01/2016, Dental Health Program staff will advertise the CWF position and promote the position to the dental community.

3. Select candidate
Between 10/2015 and 02/2016, Dental Health Program staff will interview and select an individual to fill the CWF coordinator position.

4. Provide staff training
Between 10/2015 and 03/2016, Dental Health Program staff will train the staff member to coordinate the CWF Program.

Objective 2:
2. Upgrade equipment
Between 10/2015 and 09/2016, Dental Health Program staff will establish **5** contracts (minimum) with communities to upgrade fluoridation equipment to maintain optimum fluoride levels.

Annual Activities:
1. Maintain list for fluoridation planning

Between 10/2015 and 09/2016, Dental Health Program staff will maintain a plan for short term and long term fluoridation needs and identify communities planning to expand/replace fluoridation facilities. Staff will maintain a list of potential areas to cost effectively initiate fluoridation upgrades.

2. Solicit grant proposals
Between 10/2015 and 09/2016, Dental Health Program staff will solicit, prioritize, and approve grant proposals from communities for initiation and upgrading of fluoridation equipment.

3. Evaluate fluoridation proposals
Between 10/2015 and 09/2016, Dental Health Program staff will contact field office engineers regarding evaluation of communities for fluoridation grant proposals. Staff will meet with ODW field office engineers and/or contact them regularly regarding program planning, quality assurance and technical assistance.

4. Contract for fluoridation projects
Between 10/2015 and 09/2016, Dental Health Program staff will establish contracts with communities according to VDH contracting protocols.

5. Monitor fluoridation contracts
Between 10/2015 and 09/2016, Dental Health Program staff will monitor contracts to completion including review of invoices and initiating reimbursement payments.

Objective 3:
3. Monitor water systems
Between 10/2015 and 09/2016, Dental Health Program staff, working with ODW, will maintain **143** CWF reporting systems and will enter data and monitor monthly water systems reports.

Annual Activities:
1. Maintain dual reporting systems
Between 10/2015 and 09/2016, Dental Health Program staff will serve as liaison to the CDC Community Water Fluoridation Program and maintain dual systems with CDC Water Reporting Fluoridation Systems (WFRS) with the public access side at My Water's Fluoride and Oral Health Maps according to the CDC Data Management Model and timeline.

2. Maintain water system data entry
Between 10/2015 and 09/2016, Dental Health Program staff will complete entry of water systems statewide data for CDC award eligibility.

3. Monitor water systems
Between 10/2015 and 09/2016, Dental Health Program staff will perform monthly monitoring of water supplies in conjunction with the Office of Drinking Water/DCLS through the collection, interpretation, compilation and reporting of statewide data.

4. Review inspection reports
Between 10/2015 and 09/2016, Dental Health Program staff will review inspection reports monthly and maintain a list of water systems fluoridation information.

5. Review discrepancy reports
Between 10/2015 and 09/2016, Dental Health Program staff will review the annual EPA/SDWIS/WRFS discrepancy report by the established CDC deadline.

Objective 4:
4. Provide training and education
Between 10/2015 and 09/2016, Dental Health Program staff will provide education for customers, health professionals, and communities regarding the health benefits of fluorides; collaborate with partners to expand statewide training regarding CWF; and provide technical assistance to **all interested** professionals, including VDH staff.

Annual Activities:

1. Provide education

Between 10/2015 and 09/2016, Dental Health Program staff will provide education for customers, health professionals, and communities regarding the health benefits of fluorides and fluoridation in Virginia.

2. Provide training

Between 10/2015 and 09/2016, Dental Health Program staff will collaborate with VDH Office of Drinking Water, Salem Water Treatment Plant, local health districts, and program partners to expand: statewide training for water works operators; training and educational courses to include specific water operator courses; spokesperson trainings; and the opportunity for two engineers to attend the annual CDC Basic Water Fluoridation Course.

3. Provide technical assistance

Between 10/2015 and 09/2016, Dental Health Program staff will provide technical assistance to professionals, including VDH staff. The CWF coordinator will provide assistance to public and private medical and dental health professionals regarding a broad range of fluoridation issues including health concerns, adjusted fluoride water levels by locality, and information on evidenced based research and cost effectiveness.

State Program Title: Head Start Dental Data Collection

State Program Strategy:

Program Goal:
The goal of this program is to develop and use an ongoing system of Basic Screening Survey (BSS) data collection for dental disease for children enrolled in Head Start in Virginia from 10/1/15 and 9/30/16. BSS survey data measures untreated decay, previous decay experience and urgency of dental treatment needs. Using the National Center on Health Head Start Oral Health Form for dental exams, 75% of Head Start programs will collect and submit completed forms.

Program Health Priority:
Tooth decay is the most common chronic disease of childhood, with children from low-income families carrying the heaviest burden of the disease. Virginia needs an ongoing, cost-efficient way to collect accurate disease information on the Head Start population. The use of this form will capture disease data being collected in private dental offices serving local Head Start children. This needs assessment data will help direct resources more efficiently in order to maximize preventive outcomes.

Primary Strategic Partners:
Critical partnerships to ensure program success include those groups that deal with the oral health issues of young children, such as the Virginia Head Start Association and local Head Start programs. The Dental Health Program will also continue to work with national partners, e.g., the National Center on Health to identify electronic options for data collection. Internally, we will work with the Division of Policy and Evaluation on data collection, data entry and analysis of BSS data.

Evaluation Methodology:
The Dental Health Program (DHP) will collect annual dental disease data for individual children enrolled in Head Start. The Head Start Oral Health form will be used by local dentists to record the dental status of individual Head Start children during the required annual dental exam. Once completed by the dentist, the form is returned to the local Head Start program as part of the child's health record. In addition to the BSS fields, demographic fields to be collected are the child's city, date of birth, gender, and race/ethnicity. The paper forms will be securely mailed to VDH for entry into a database for analysis until an electronic process is developed. The DHP will work with the epidemiologist in the Division of Policy and Evaluation in the Office of Family Health Services to analyze data.

State Program Setting:
Other: Local dental offices and local Head Start programs.

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Tonya Adiches
Position Title: Dental Health Programs Manager
State-Level: 5% Local: 0% Other: 0% Total: 5%
Position Name: Delphine Anderson
Position Title: Program Support Technician
State-Level: 5% Local: 0% Other: 0% Total: 5%
Position Name: Earl Taylor
Position Title: Program Support Technician
State-Level: 5% Local: 0% Other: 0% Total: 5%

Total Number of Positions Funded: 3

Total FTEs Funded: 0.15

National Health Objective: HO OH-16 Oral and Craniofacial State-Based Health Surveillance System

State Health Objective(s):

Between 10/2015 and 09/2016, Dental Health Program staff will complete the collection, analysis and reporting of the BSS screening survey for 75% of Virginia Head Start programs to identify untreated decay, previous decay experience and urgency of dental treatment needs.

Baseline:
The Dental Health Program collected 203 forms from eight Head Start programs from January 1, 2015 through April 31, 2015, as a pilot project for BSS data collection. Data entry and analysis is incomplete. The 2013 – 2014 Virginia Head Start Program Information Report for Health Services indicates 14.33% of Head Start children who received a dental exam were "diagnosed as needing dental treatment", which correlates to "untreated decay".

Data Source:
Dental Health Program reports of dental forms received; 2013 – 2014 Virginia Head Start Program Information Report for Health Services

State Health Problem:

Health Burden:
As reported nationally and in Virginia by Head Start parents and staff, the number one health issue affecting children enrolled in Head Start nationwide is the lack of access to oral health services. Approximately 80% of the health burden of tooth decay is carried by 20 - 25% of the child population – those who are of low income status – illustrating a profound disparity among the low income population. The Head Start population reflects a higher percentage of racial and ethnic minorities than the general U.S. population, with approximately 60% of enrolled children being of black, multi-racial, or ethnic backgrounds. Additionally, 10% of enrollment spots are reserved for children with disabilities and special health care needs who are also at high risk for dental disease and difficulty accessing oral health services. While Virginia has increased the number of dentists who accept Medicaid insurance, there are still shortages of Medicaid dentists in most areas of the state.

Target Population:
Number: 15,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 15,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Location: Entire state
Target and Disparate Data Sources: Head Start: An Opportunity to Improve Oral Health of Children and Families http://mchoralhealth.org/PDFs/HSOHFactSheet.pdf

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: ASTDD State-Based Oral Health Surveillance System:
http://www.astdd.org/docs/BPASurveillanceSystem.pdf
Best practice for surveillance of the Head Start population is outlined in a report from Nevada where survey findings of large unmet oral health needs led to a comprehensive report disseminated to policymakers, funders, educators and other stakeholders throughout the state to determine strategies to aid in the development of new interventions to prevent disease in this high risk population of young children. North Dakota reported the only Head Start data available in their state is through the Head Start Program Information Report (PIR), which is currently the only source of data in Virginia.

Association of State and Territorial Dental Directors, National Maternal and Child Oral Health Resource Center. 2011. Strategies to Improve Collaboration Between State Oral Health Programs and Head Start State Collaboration Offices. Sparks, NV: Association of State and Territorial Dental Directors; Washington, DC: National Maternal and Child Oral Health Resource Center.
http://mchoralhealth.org/PDFs/SOHP_HSSCO_TipSheet.pdf
This paper summarizes the role of the State Oral Health Program (SOHP) and the Head Start State Collaboration Office (HSSCO) and outlines the progress of the Association of State and Territorial Dental Directors (ASTDD) to enhance collaboration between the two organizations on the state level. Virginia's collaboration efforts began in 2005 with a statewide Head Start Oral Health Summit. The report recommends strategies to continue these collaborative relationships between the SOHP, the HSSCO, and other stakeholders that support oral health needs assessments and surveillance.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $20,190
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

1. Develop database
Between 10/2015 and 09/2016, Dental Health Program staff will develop **1** database for data entry and analysis.

Annual Activities:

1. Develop database
Between 10/2015 and 09/2016, Dental Health Program staff will work with internal evaluation staff to develop a database for entry of hard copy forms and data analysis.

2. Train staff
Between 10/2015 and 09/2016, Dental Health Program staff will train staff on data entry.

Objective 2:

2. Collect data forms
Between 10/2015 and 09/2016, Dental Health Program staff will collect **1,500** dental forms from 75% of Virginia Head Start programs.

Annual Activities:
1. Provide instructions
Between 10/2015 and 09/2016, Dental Health Program staff will email instructions and forms to all Virginia Head Start programs for data collection and mailing, and will attend HAC meetings to answer questions.

2. Distribute supplies
Between 10/2015 and 09/2016, Health Program staff will distribute secure mailing supplies to participating Head Start programs at the January HAC meeting.

3. Monitor forms intake
Between 10/2015 and 09/2016, Dental Health Program staff will monitor receipt of incoming mailed dental forms.

Objective 3:
3. Complete data entry
Between 10/2015 and 09/2016, Dental Health Program staff will conduct **all** data entry.

Annual Activities:
1. Coordinate timeline
Between 10/2015 and 09/2016, Dental Health Program staff will work with internal data entry staff to establish timeline on data entry.

2. Enter data
Between 10/2015 and 09/2016, Dental Health Program staff will review forms and enter data.

Objective 4:
4. Investigate data options
Between 10/2015 and 09/2016, Dental Health Program staff will investigate **2** electronic data options through consultation with state and federal partners.

Annual Activities:
1. Collaborate with Head Start staff
Between 10/2015 and 09/2016, Dental Health Program staff will contact the executive director of the Virginia Head Start Association and the office director of the State Collaborative regarding discussions with regional and national colleagues.

2. Consult partners
Between 10/2015 and 09/2016, Dental Health Program staff will update the National Center on Health and ASTDD on Virginia's progress and seek status of national discussions regarding the use of the form and electronic options.

Objective 5:
5. Analyze and report data
Between 10/2015 and 09/2016, Dental Health Program staff will develop **1** report on findings of the BSS survey for distribution to key partners.

Annual Activities:
1. Analyze data
Between 10/2015 and 09/2016, Dental Health Program staff will work with Policy and Evaluation staff to complete analysis of data.

2. Report data
Between 10/2015 and 09/2016, Dental Health Program staff will complete a written report to be distributed to key partners, e.g. VA Head Start Association and local Head Start programs.

State Program Title: Injury and Violence Prevention Program

State Program Strategy:

Program Goal:
The goal of the Injury and Violence Prevention Program is to increase the number of state and local level agencies, organizations, and groups implementing effective prevention strategies.

Program Health Priority:
Injuries impact everyone at some point in their lives and represent the leading cause of death in the U.S. and Virginia for those 1-44 years of age. The Centers for Disease Control and Prevention estimates that every three minutes someone in the U.S. dies from an intentional or unintentional injury. Although death is the most severe result of injury, it represents only part of the problem. The majority of those who incur injuries survive. Depending on the severity of the injury, victims may be faced with life-long mental, physical and financial problems as a result of loss of productivity and stress to the victim, family, and other caregivers.

Unfortunately, because injuries are so commonplace, they are often accepted as an inevitable part of life. However, research has proven that the causes of injuries are predictable and preventable and not randomly occurring accidents. Injuries can be prevented through potentially modifiable factors that affect the occurrence and severity of injury, such as behavior change, policy, environment and the use of safety devices.

The Injury and Violence Prevention Program supports promising and best practice injury prevention activities at the local level that address leading or emerging injury issues.

Primary Strategic Partners:
In addition to collaborating with relevant programs in the VDH Offices of Family Health Services, Emergency Medical Services, and the Chief Medical Examiner, the Injury Prevention Program partners with a variety of organizations and agencies at the state and local levels depending on the mechanism of injury being addressed. These include but are not limited to drug free organizations, Safe Kids coalitions, schools, child care centers, fire and police departments, health systems, Poison Control Centers, Virginia High School League, Virginia Association of Independent Schools, Virginia Chapter of the American Academy of Pediatrics, Bike Walk Virginia, AAA divisions, Anthem Blue Cross and Blue Shield of VA, VA Association of Health, Physical Education, Recreation and Dance, VA Recreation and Park Society, VA Safe Routes to School Network, VA Fire and Life Safety Coalition, Virginia Association of School Nurses, Brain Injury Association of VA, Drive Smart Virginia, and the Virginia Departments of Social Services, Criminal Justice Services, Education, Aging and Rehabilitative Services, Fire Programs, Conservation and Recreation, Motor Vehicles and Transportation.

Evaluation Methodology:
All funded projects will require an evaluation plan following the RE-AIM framework to include, where applicable, the systematic measurement of the following: the number of participants in training events and the level of exposure for awareness activities (Reach); the impact of trainings and educational sessions on behavioral change and changes in the rates of available Virginia injury data (Efficacy); the number of new partnerships and/or policies developed to support implementation (Adoption); fidelity to best practices at the project level (Implementation); and the extent to which the program becomes institutionalized or part of the routine organizational practice (Maintenance). Outcomes of awareness and training activities will be assessed through tracking of activities; monitoring of audience exposures to information provided; and behavior change that results from activities. In addition, data on the type and number of distributed resources will be collected.

State Program Setting:

Community health center, Local health department, Medical or clinical site, State health department, Other: Injury and violence advocacy groups

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Vanessa Walker Harris
Position Title: DPHP Director
State-Level: 0% Local: 0% Other: 2% Total: 2%
Position Name: Heather Board
Position Title: IVTP Programs Manager
State-Level: 25% Local: 0% Other: 0% Total: 25%
Position Name: Lisa Wooten
Position Title: Injury Prevention Program Supervisor
State-Level: 5% Local: 0% Other: 0% Total: 5%
Position Name: JoAnn Wells
Position Title: Injury Prevention Outreach Coordinator
State-Level: 0% Local: 5% Other: 0% Total: 5%
Position Name: Jennifer Schmid
Position Title: IVP Program Support
State-Level: 0% Local: 0% Other: 5% Total: 5%
Position Name: Anne Zehner
Position Title: Epi Analyst
State-Level: 25% Local: 0% Other: 0% Total: 25%

Total Number of Positions Funded: 6
Total FTEs Funded: 0.67

National Health Objective: HO IVP-1 Total Injury

State Health Objective(s):

Between 10/2014 and 09/2020, VDH will reduce the rate of injury related deaths by 3% from the 2012 baseline of 51.9 per 100,000 to 50.3 per 100,000 by 2020.

Between 10/2014 and 09/2020, VDH will reduce the rate of injury related hospitalization by 5% from the 2012 baseline of 428.4 per 100,000 to 407 per 100,000 by 2020.

Baseline:
There were 51.9 deaths per 100,000 in 2012.

There were 428.4 hospitalizations per 100,000 in 2012.

Data Source:
Vital Records

Virginia Health Information

State Health Problem:

Health Burden:
Injuries represent the leading cause of death in the U.S. and Virginia for those 1-44 years of age. The 2013 unintentional injury death rate for all Virginians was 33.2 per 100,000. Although death is the most severe result of injury, the majority of those who incur injuries survive. The 2013 unintentional injury hospitalization rate for all Virginians was 343.17 per 100,000. Depending on the severity of the injury,

victims may be faced with life-long mental, physical and financial problems as a result of lost productivity and stress to the victim, family and other caregivers. Injuries impact everyone regardless of age, race or economic status. Because injuries are so commonplace, they are often accepted as an inevitable part of life. However, research has demonstrated that injuries can be prevented through modifiable factors such as behavior, policy and the environment.

Target Population:
Number: 7,882,590
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 7,882,590
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: CDC Recommends: The Prevention Guidelines System, Healthy People 2020, Safe Kids Worldwide, Home Safety Council, Safe States Alliance, Children's Safety Network, Harborview Injury Prevention and Research Center, Safe Communities America Program

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $238,100
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $66,509
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Assure a competent workforce

Between 10/2015 and 09/2016, the VDH Injury and Violence Prevention Program will provide resources, technical assistance and training to build and maintain a statewide injury prevention infrastructure, with emphasis on expanding statewide and local capacity for rigorous data collection, analysis, reporting and completing a comprehensive program evaluation to **all interested** stakeholders and partners.

Annual Activities:

1. Provide training and education

Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will continue to support a statewide network of practitioners through the coordination of two regional meetings to support local capacity and sustainability of best practice strategies.

2. Host conference

Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will coordinate with the Virginia Trauma System to host a statewide conference for injury and violence professionals.

3. Provide outreach and education

Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will share resources through the Injury Prevention Network listerv on a routine basis to support local efforts.

4. Collaborate with partners

Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will coordinate the revision of the statewide Injury Prevention Strategic Plan.

Objective 2:

2. Analyze data

Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will develop **3** data briefs to support the development of data driven programmatic activities for the prevention of injuries and violence.

Annual Activities:

1. Maintain access to data

Between 10/2015 and 09/2016, VDH will maintain public access to currently available injury hospitalization and death data by updating the Virginia Online Injury Reporting System, VOIRS, with 2014 data.

2. Provide data briefs

Between 10/2015 and 09/2016, VDH will provide targeted data briefs to support the development of data driven programmatic activities for the prevention of injuries and violence.

Objective 3:

3. Inform and educate

Between 10/2015 and 09/2016, the VDH Injury and Violence Prevention Program will conduct **1** webinar for community librarians for increasing acquisition of knowledge in leading community injury prevention education efforts within community libraries.

Annual Activities:

1. Provide training and education

Between 10/2015 and 09/2016, VDH will develop and release a webinar to community librarians, focusing on knowledge and skills for community library patrons to apply in promoting best practice in community injury prevention programming across the lifespan.

Objective 4:

4. Collaborate with partners

Between 10/2015 and 09/2016, the VDH Injury and Violence Prevention Program will implement **1** pilot project in the development of a community-based youth violence prevention initiative, utilizing a collective impact format.

Annual Activities:

1. Collaborate with partners

Between 10/2015 and 09/2016, the Richmond City Health Department will expand the existing Youth Violence Prevention Workgroup of the Richmond Juvenile Justice Collaborative to include additional non-governmental sectors—e.g., private businesses, community/neighborhood groups, faith-based organizations, foundations/philanthropic community – and youth and families.

2. Analyze data

Between 10/2015 and 09/2016, the Richmond City Health Department will take the lead working with and through the Youth Violence Prevention Workgroup of the Richmond Juvenile Justice Collaborative to develop a root cause analysis and a summary of Richmond-specific youth violence data. Findings from the assessment will be used to define the extent of the needs (gap analysis) that exist in the community and the depth of the assets available within the community to address those needs specific to youth violence.

3. Complete survey

Between 10/2015 and 09/2016, the Richmond City Health Department will complete a comprehensive survey of Adverse Childhood Experience's (ACE) in Richmond to determine ACE prevalence as a baseline model for long-term youth violence strategic planning.

4. Collaborate on strategic plan development

Between 10/2015 and 09/2016, the Richmond City Health Department will establish long-term youth violence prevention goals and identify risk and protective factors to be modified to achieve those goals through the development of a strategic plan to guide the efforts of the Youth Violence Prevention Workgroup of the Richmond Juvenile Justice Collaborative.

Objective 5:

5. Develop data collection system

Between 10/2015 and 09/2016, the VDH Injury and Violence Prevention Program will develop **1** data collection system for the Low Income Safety Seat Distribution and Education Program (LISSDEP) to support the efficiency of administrative operations, effectiveness of programmatic resource distribution among LISSDEP distribution sites and facilitate program evaluation.

Annual Activities:

1. Develop system

Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will partner with the VDH Office of Information Management to develop a web-based database to collect and analyze safety seat distribution data from LISSDEP distribution sites.

State Program Title: OFHS Program Support – Behavioral Risk Factor Surveillance System (BRFSS)

State Program Strategy:

Program Goal:
During the last 30 years, the Virginia BRFSS has become the main source for annual, state-based health information in Virginia. Since 2002, the BRFSS program has provided data to each of the 35 health districts in an effort to inform public health actions and improve the health of all citizens. For 2015, the primary goal of the Virginia BRFSS program is to continue the legacy of providing quality information to anyone who wants to understand and address health status and health risk behaviors.

Program Health Priority:
The program health priority is data collection for health-related risk behaviors among adults.

Primary Strategic Partners:
Primary strategic partners include local health districts, other state agencies, non-profit and advocacy groups (such as the Virginia Asthma Coalition, the Partnership for People with Disabilities, and others), researchers, and the public.

Evaluation Methodology:
VDH will measure the number of survey completions, the percent of cell-phone only completions, and the speed with which data tables are posted to the VDH website.

State Program Setting:
State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: TBD
Position Title: BRFSS Coordinator
State-Level: 40% Local: 0% Other: 0% Total: 40%
Position Name: Danielle Henderson
Position Title: CHA Supervisor
State-Level: 10% Local: 0% Other: 0% Total: 10%

Total Number of Positions Funded: 2
Total FTEs Funded: 0.50

National Health Objective: HO PHI-14 Public Health System Assessment

State Health Objective(s):
Between 10/2015 and 09/2016, VDH will increase the availability and use of BRFSS data.

Baseline:
The number of surveys completed on a cell phone is 2,700. The percentage of surveys completed with people who do not have a landline (cell phone only) is 30%. The amount of time it takes to post data tables to the web site is 90 days.

Data Source:

Behavioral Risk Factor Surveillance System (BRFSS), 2014 calendar year

State Health Problem:

Health Burden:
BRFSS is the most comprehensive source of data on health-related risk behaviors among adults in Virginia. The state-level survey funded by the CDC provides data that are aggregated across the state, rather than more detailed local-level analyses. The 35 health districts are the primary users of BRFSS data. Other residents of Virginia, including researchers, employees of other state agencies, hospitals, and health-related organizations also use the data.

Target Population:
Number: 35
Infrastructure Groups: State and Local Health Departments

Disparate Population:
Number: 35
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: VDH uses a Call for Proposal process through which VDH offices, other state agencies, and members of the public can submit proposals to add questions to the BRFSS. These proposals are evaluated by the BRFSS Workgroup, and the State Health Commissioner makes a final determination regarding the questions included on the survey.

The call for proposal process has been in use for the BRFSS survey for a number of years, and incorporates changes and best practices based on those years of experience. Virginia implemented several changes in 2014, including posting a Virginia telephone number on the caller ID of those who are contacted, and collecting the telephone numbers of those who do not wish to participate in the survey. In 2015, VDH increased the proportion of cell phone only interviews and better aligned the data collection with the data needs of the Chronic Disease Division.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $476,749
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Collect data
Between 10/2015 and 09/2016, VDH will collect **3,000** surveys on health risks among adults.

Annual Activities:
1. Conduct surveys

Between 10/2015 and 09/2016, VDH will conduct surveys to maintain cell-phone only (no landline) at 30%.

2. Collect surveys
Between 10/2015 and 09/2016, VDH will collect 3,000 cell phone surveys.

Objective 2:
2. Provide data
Between 10/2015 and 09/2016, VDH will develop **25** data tables and post them to the web site.

Annual Activities:
1. Post data
Between 10/2015 and 09/2016, VDH will post data tables to the website within 90 days of receiving the data file.

2. Provide reports
Between 10/2015 and 09/2016, VDH will provide data reports on current year data (when available), trends, and other analyses as requested.

Objective 3:
3. Produce small area estimates
Between 10/2015 and 09/2016, VDH will collect **1** oversample of at least one health district to produce small area estimates (county data) for ten health indicators.

Annual Activities:
1. Identify oversample
Between 10/2015 and 06/2016, VDH will identify and begin an oversample of at least one health district that contains multiple counties.

2. Develop a model
Between 10/2015 and 09/2016, VDH will develop a model to produce small area estimates for at least ten health indicators using 2014 and 2015 data.

3. Compare estimates
Between 10/2015 and 09/2016, VDH will compare the direct and indirect estimates for the ten health indicators.

4. Share results
Between 10/2015 and 09/2016, VDH will share the results and estimated cost of small area estimation with VDH staff.

State Program Title: OFHS Program Support – Pregnancy Risk Assessment Monitoring System (PRAMS)

State Program Strategy:

Program Goal:
The primary program goal is to maintain the survey response rate above 60%.

Program Health Priority:
PRAMS provides population-level data on Healthy People 2020 goals related to access to health services, injury and violence prevention, immunization, maternal and child health, family planning, early and middle childhood, mental health and mental disorders, tobacco use, and oral health.

Primary Strategic Partners:
Primary program partners include local health districts, state agencies (e.g., Department of Medical Assistance Services, Department of Behavioral Health and Developmental Services), researchers, and the March of Dimes.

Evaluation Methodology:
VDH will measure the number of survey completions against the improved baseline of 62.8% (2015 un-weighted response rate as of 9/2015).

State Program Setting:

State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Sara Varner
Position Title: PRAMS Coordinator
State-Level: 43% Local: 0% Other: 0% Total: 43%
Position Name: Kitty Deiss
Position Title: PRAMS Data Manager
State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 2
Total FTEs Funded: 0.93

National Health Objective: HO PHI-7 National Data for Healthy People 2020 Objectives

State Health Objective(s):

Between 10/2015 and 09/2016, VDH will maintain its un-weighted PRAMS response rate (as measured in the PIDS system) above 60%.

Baseline:
The un-weighted 2015 response rate was 62.8% (measured in September 2015).

Data Source:
PRAMS Data System (PIDS)

State Health Problem:

Health Burden:
PRAMS determines the health burdens affecting pregnant women and women who have recently given birth. PRAMS is specifically designed to collect data related to potential correlates of infant mortality and other poor birth outcomes including low birthweight and preterm birth. Women are randomly selected for participation in the PRAMS survey. Potential participants are identified through Virginia's vital records database. The projected target population is 1,132 women. The random selection process allows PRAMS data to be generalized to all new mothers within Virginia.

Target Population:
Number: 40
Infrastructure Groups: State and Local Health Departments, Community Based Organizations, Health Care Systems, Other

Disparate Population:
Number: 40
Infrastructure Groups: State and Local Health Departments, Community Based Organizations, Health Care Systems, Other

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: VDH is following the recommendations of the CDC, as well as best practices implemented in other states to identify and test methods to increase the response rate.

VDH has conducted the Pregnancy Risk Assessment Monitoring System (PRAMS) survey since 2007. However, the national standard response rate of 60% has not previously been met. PRAMS is the sole data source for many maternal and child health indicators and provides critical data for ongoing initiatives and grants in Virginia.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $65,100
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Conduct survey
Between 10/2015 and 09/2016, VDH will conduct **1,132** PRAMS surveys of Virginia women.

Annual Activities:
1. Mail surveys
Between 10/2015 and 09/2016, VDH will mail surveys to 1,132 women for completion.

2. Provide follow-up phone calls
Between 10/2015 and 09/2016, VDH will provide follow-up phone calls and incentives to maintain response rate above 60%.

3. Track and record data
Between 10/2015 and 09/2016, VDH will track and record data in the PIDS system.

Objective 2:
2. Distribute data
Between 10/2015 and 09/2016, VDH will distribute data to inform and improve the health of the MCH population to **all identified** internal and external stakeholders.

Annual Activities:
1. Identify stakeholders
Between 10/2015 and 09/2016, VDH will identify internal and external stakeholders who would benefit from PRAMS data.

2. Respond to requests
Between 10/2015 and 09/2016, VDH will respond to all requests for PRAMS data, analysis and reporting.

3. Produce reports
Between 10/2015 and 09/2016, PRAMS staff will work with VDH communications staff to produce reports and materials using PRAMS analysis.

State Program Title: OFHS Program Support – Youth Risk Behavior Survey (YRBS) and School Health Profiles (SHP)

State Program Strategy:

Program Goal:
The primary goal is to obtain data at the state and regional levels to better inform schools, health districts, and communities about the most prevalent health-related risk behaviors among youth in these geographic areas. Three school districts requested to collect division-level data that will help to more effectively deliver programs and services to their students.

Program Health Priority:
The health priority is data collection for health-related risk behaviors among youth.

Primary Strategic Partners:
Primary strategic partners include local health districts, the Department of Education, school divisions (including school administrators and teachers) and community groups. The Virginia Foundation for Healthy Youth is also a partner in administering the state-level YRBS.

Evaluation Methodology:
The program will be evaluated to ensure that data is collected for elected school divisions and that data tables are provided to school divisions and local health districts for use in determining priority areas related to health-related risk behaviors among youth.

State Program Setting:
Local health department, Schools or school district

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Sarah Conklin
Position Title: YRBS Coordinator
State-Level: 55% Local: 0% Other: 0% Total: 55%
Position Name: Danielle Henderson
Position Title: CHA Supervisor
State-Level: 5% Local: 0% Other: 0% Total: 5%

Total Number of Positions Funded: 2
Total FTEs Funded: 0.60

National Health Objective: HO PHI-7 National Data for Healthy People 2020 Objectives

State Health Objective(s):
Between 10/2015 and 09/2016, VDH will conduct a state-wide survey of high school and middle school health behaviors. Over 7,500 high school students in 92 schools and 4,000 middle school students in 54 schools will be sampled for the state-level YRBS. The sample design will produce state level estimates and some local estimates. VDH will also conduct a system of surveys assessing school health policies

and practices across 100 schools in Virginia. (This survey is conducted every two years among middle and high school principals and lead health education teachers.)

Baseline:
In 2013, a total of 116 high schools and 129 middle schools participated in the state-level YRBS. In addition, a total of 265 middle, combined junior/senior high schools and high schools participated in the SHP, with a 70% response rate. Virginia Tech was contracted to complete data analysis and data reporting. A handout was produced that included tables and graphs of the 2014 middle and high school results. A trend analysis also was conducted from 1998 to 2014.

Data Source:
CDC School Health Profiles

State Health Problem:

Health Burden:
There are limited sources of data on health-related risk behaviors among youth in Virginia other than the YRBS. The state-level survey funded by CDC provides data that is aggregated across the state, rather than more detailed local-level analyses. Elected health district/school division School Health Profiles will allow state agencies to make decisions about future policy and social change implications. This data will be useful to the 35 local health districts and the 133 school divisions.

Target Population:
Number: 168
Infrastructure Groups: State and Local Health Departments, Other

Disparate Population:
Number: 168
Infrastructure Groups: State and Local Health Departments, Other

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $117,818
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Collect SHP data
Between 10/2015 and 09/2016, VDH will collect **1** School Health Profile on 100 schools in Virginia.

Annual Activities:
1. Identify schools
Between 10/2015 and 06/2016, VDH will identify middle and high schools in Virginia to participate in the SHP.

2. Conduct survey
Between 10/2015 and 06/2016, VDH will conduct SHP through an online survey to principals and health teachers.

3. Conduct analysis
Between 10/2015 and 09/2016, VDH will provide data to CDC and conduct analysis and reporting.

Objective 2:
2. Collect survey data
Between 10/2015 and 09/2016, VDH will collect **8,400** surveys on health behaviors from students in 149 schools.

Annual Activities:
1. Select survey participants
Between 10/2015 and 10/2015, VDH will work with selected schools to randomly select classrooms to participate in the survey and will send out notification of the survey to parents.

2. Conduct surveys
Between 10/2015 and 12/2015, VDH will conduct surveys in all identified school and classrooms.

3. Provide data
Between 10/2015 and 12/2015, VDH will provide data to CDC contractor for weighting and analysis.

4. Report findings
Between 10/2015 and 09/2016, VDH will post and disseminate reports on survey findings.

Objective 3:
3. Prepare for survey
Between 10/2015 and 09/2016, VDH will develop **1** standardized process to assist school divisions in obtaining local data.

Annual Activities:
1. Secure software
Between 10/2015 and 06/2016, VDH will explore and secure software for in-house scanning and informatics capacity for electronic surveying.

2. Develop a Call for Proposal
Between 10/2015 and 09/2016, VDH will develop and publish a Call for Proposal for a vendor to assist with the 2017 YRBS.

3. Publish data
Between 10/2015 and 09/2016, VDH will publish and disseminate 2015 YRBS data to solicit local health districts and school divisions for oversampling in 2017.

State Program Title: Oral Health Assessment of Virginia's Elders

State Program Strategy:

Program Goal:
The goal of this program is primary data collection to describe the oral health status among the older adult population in targeted groups throughout the state as part of an oral health surveillance system that collects specific data for use in the planning, implementation, and evaluation of public health practice.

Program Health Priority:
Priority dental public health concerns include the prevalence and severity of oral diseases and disorders, their potential impact on general health and well-being, and the significant disparities related to health and health care. Historically, oral health data collection and reporting have focused primarily on children. However, profound oral health and oral health care access disparities exist for adult minority, low income and low education populations.

Primary Strategic Partners:
The partnerships that are critical for this program to succeed include those with other agencies that deal with the oral health issues of the elderly. Those partners include Virginia Association of Area Agencies on Aging, Virginia Association of Nursing Home Administrators, Virginia Association of Non-profit Homes for the Aging, and local nursing homes/assisted living facilities. The Association of State and Territorial Dental Directors (ASTDD) is a partner regarding screening tools and assistance with analysis of the data.

Evaluation Methodology:
The Dental Health Program will work with the epidemiologist in the Division of Policy and Evaluation in the Office of Family Health Services, as well as obtain technical assistance from ASTDD to review survey questions, determine sample size, analyze data, and use the ASTDD Basic Screening Survey (BSS) for the clinical screening tool.

State Program Setting:
State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Tonya Adiches
Position Title: Dental Health Programs Manager
State-Level: 10% Local: 0% Other: 0% Total: 10%
Position Name: Delphine Anderson
Position Title: Program Support Technician
State-Level: 10% Local: 0% Other: 0% Total: 10%
Position Name: Earl Taylor
Position Title: Program Support Technician
State-Level: 25% Local: 0% Other: 0% Total: 25%

Total Number of Positions Funded: 3
Total FTEs Funded: 0.45

National Health Objective: HO OH-16 Oral and Craniofacial State-Based Health Surveillance System

State Health Objective(s):

Between 10/2015 and 09/2016, Dental Health Program staff will complete the collection, analysis, and reporting of oral health survey and screening data for older adults in two settings (nursing home/ assisted living residents and attendees of senior congregate meal sites) as part of the Virginia Oral Health Surveillance System (OHSS).

Baseline:
41.3% untreated decay among nursing home residents; 63.6% untreated decay among well elders in congregates meal sites; Virginia OHSS completed an Elder BSS in 2006.

Data Source:
Survey of the Oral Health of Elder Virginians – 2008; Virginia OHSS, Dental Health Program, Virginia Department of Health (VDH)

State Health Problem:

Health Burden:
Over the past several years, there have been significant improvements in the oral health status of American adults, but not all adults have benefited from advances in oral health care and dental disease prevention efforts. Additionally, as the population has aged, there has been a rise in the decay rate among older adults who are more likely to experience oral health complications that require extensive treatment compared to younger adults. In recent years, researchers have found evidence linking bacteria in the mouth to overall health. While the direct link between oral bacteria and heart disease and stroke is uncertain, people with gum disease are twice as likely to have certain types of heart disease and people diagnosed with acute cerebrovascular ischemia were more likely to have an oral infection when compared to those in control groups. People with diabetes are more likely to have periodontal disease than people without diabetes. Periodontal disease is often considered the sixth ranking complication of diabetes, causing bone and tissue loss at a greater rate and making the diabetes harder to control. The impact of poor oral health can have far-reaching consequences that result in detriments to overall health and well-being including the ability to eat and maintain adequate nutritional status.

The National Oral Health Surveillance System served as a model for the Virginia OHSS. Data collection intervals have been determined and include “open mouth” screening surveys such as the Elder BSS, as well as data from the Behavioral Risk Factor Surveillance System, state cancer registries, and fluoridation programs. Completing an Elder BSS will describe the status of important oral conditions in this population, analyze trends as multiple years of data are collected, and make data available for program decision making.

Target Population:
Number: 1,500
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 1,275
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 65 years and older
Gender: Female and Male
Geography: Rural and Urban

Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Local Area Agencies on Aging (congregate meal participants) and VDH Office of Licensure and Certification (Nursing home enrollment).

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The Surgeon General's Report on Oral Health stated: "Having state-specific and local data that augment national data is critical in identifying high-risk populations and in addressing oral health disparities." The report further proposed that implementation strategies to overcome barriers in oral health disparities should include building and supporting epidemiologic and surveillance efforts to identify patterns of disease and populations at risk.

Best Practice Guidelines for Oral Health Surveillance from ASTDD include:

Impact/Effectiveness: A state-based oral health surveillance system contains a core set of measures that describes the status of important oral health conditions and behaviors. These measures serve as benchmarks for assessing progress in achieving good oral health. An oral health surveillance system communicates data and information to responsible parties and to the public in a timely manner. ASTDD has also developed guidance on the collection of data from this population based on national questionnaires and the Basic Screening Survey.

Efficiency: Data collection is managed on a periodic but regular schedule. Cost-effective strategies are used in collecting, analyzing and communicating surveillance data.

Collaboration/Integration: Partnerships are established to leverage resources for data collection. Data and findings from the surveillance system are used to integrate oral health into other health programs.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $81,276
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

1. Complete survey design

Between 10/2015 and 11/2015, the Dental Health Program will develop **1** complete survey design, collaborate and obtain permission from partners with agencies that have older adults who can represent the targeted populations in the oral health survey and screening.

Annual Activities:

1. Determine sample

Between 10/2015 and 10/2015, the OFHS epidemiologist will determine the sample needed to represent the older population in three settings (homebound, nursing homes, and congregate well elders) across the state in five health planning regions.

2. Determine questionnaire
Between 10/2015 and 10/2015, the Centers for Disease Control and Prevention grant manager will review the questionnaire utilized in the 2008 survey as well as other sources for oral health questionnaires and recommendations from ASTDD, make modifications, and tailor the questions to address salient demographic and oral health factors.

3. Verify survey instrument
Between 10/2015 and 10/2015, the Centers for Disease Control and Prevention grant manager and the OFHS Epidemiologist will determine the validity and reliability of the survey instrument across each of the elderly populations.

4. Obtain IRB approval
Between 10/2015 and 10/2015, the Centers for Disease Control and Prevention grant manager will submit survey documents to obtain Institutional Review Board approval.

5. Obtain approval from sites
Between 10/2015 and 11/2015, the Centers for Disease Control and Prevention grant manager will obtain permission to survey elder individuals in nursing homes, assisted living facilities and congregate meal sites.

Objective 2:
2. Complete data collection
Between 10/2015 and 03/2016, the Dental Health Program will collect **1,500** surveys (primary data) of the oral health status of older adults in nursing home/assisted living facilities and congregate meal sites for well elders.

Annual Activities:
1. Obtain consent
Between 10/2015 and 12/2015, the remote dental hygienists will obtain consent from participants and/or participant families and caregivers to participate in the screening.

2. Calibrate examiners
Between 10/2015 and 11/2015, the Centers for Disease Control and Prevention grant manager will train interviewers to ensure that the questionnaire is administered properly and uniformly for every survey respondent, and train and calibrate dental examiners to perform the clinical exam in accordance with the protocols outlined from the ASTDD Basic Screening Survey (BSS), which collects oral health data regarding tooth decay, soft tissue and gum disease, tooth loss resulting from dental disease, denture use and wear, and oral hygiene.

3. Conduct survey
Between 10/2015 and 03/2016, the remote dental hygienist examiners will collect the survey and clinical data from consenting older adults in nursing home/assisted living facilities and congregate meal sites for well elders, as well as administer a questionnaire that includes questions about dental care access and overall health.

Objective 3:
3. Analyze data and complete report
Between 10/2015 and 09/2016, the Dental Health Program will develop **1** report of the oral health status of older adults in nursing homes, assisted living facilities and congregate meal sites for well elders.

Annual Activities:
1. Develop database
Between 10/2015 and 04/2016, the OFHS epidemiologist will work with ASTDD to develop the Microsoft Access database for the data to be collected.

2. Enter data

Between 10/2015 and 06/2016, the Dental Health Program data entry operator will enter the data collected into the Microsoft Access database.

3. Analyze data
Between 10/2015 and 08/2016, the OFHS epidemiologist will work with ASTDD to clean and analyze the data to be representative of the five health planning regions in the state.

4. Complete and distribute report
Between 10/2015 and 09/2016, the Centers for Disease Control and Prevention Grant Manager will complete a report and submit findings to the National Oral Health Surveillance System, as well as internal and external stakeholders and groups.

State Program Title: Oral Health Care Access for Children with Special Health Care Needs (CSHCN)

State Program Strategy:

Program Goal:
The goal of this program is to continue to provide two-day educational seminars for dental professionals with a hands-on clinical component to encourage the dental treatment of CSHCN. Trainings will be provided in three different health districts within the Commonwealth of Virginia that have been identified as areas with the greatest oral health disparities for CSHCN.

Program Health Priority:
The priority of the program is to increase access to trained dental providers willing to treat CSHCN and decrease the oral health disparities in this population of children through education of providers and maintenance of the Virginia Department of Health (VDH) online provider directory. *Oral Health for CSHCN: Priorities for Action - Recommendations from an MCHB Expert Meeting, April 2008* promotes strategies for improving oral health for CSHCN and discusses the need for education and training of current and future professionals. One strategy is to "support oral health education and training for general health professionals and oral health professionals, and facilitate such education and training".

Primary Strategic Partners:
The project will include collaboration with the Virginia Dental Association Foundation and Virginia Dental Association to provide dental continuing education (CE) credits for participants and promotion for the courses. In addition, collaboration with the Virginia Commonwealth University School of Dentistry will allow pediatric dental residents to participate in the courses as assistant instructors, as well as the potential inclusion of dental students as oral health educators.

Evaluation Methodology:
In order to confirm increased capacity of dental providers available to treat CSHCN, the number of providers trained will be monitored. A post-training survey administered four to six months after each training completion will determine any change in dental office practices related to CSHCN. In addition, the number of dentists registered on the VDH online provider directory for dentists willing to treat CSHCN will be monitored and kept up to date with the most current information on each dentist and practice through the use of trainings and mailings for current and potential providers.

State Program Setting:
Community health center, Local health department, State health department, Other: Dental clinics

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Tonya Adiches
Position Title: Dental Health Programs Manager
State-Level: 10% Local: 0% Other: 0% Total: 10%
Position Name: Delphine Anderson
Position Title: Program Support Technician
State-Level: 10% Local: 0% Other: 0% Total: 10%
Position Name: Earl Taylor
Position Title: Program Support Technician
State-Level: 20% Local: 0% Other: 0% Total: 20%

Total Number of Positions Funded: 3

Total FTEs Funded: 0.40

National Health Objective: HO OH-7 Use of Oral Health Care System

State Health Objective(s):

Between 10/2015 and 09/2016, the Dental Health Program will plan and provide up to four educational opportunities for dental providers to increase their willingness to treat CSHCN and increase access to dental services for CSHCN. Dental staff will update the VDH online provider directory for dentists willing to treat CSHCN to accurately reflect provider status by location.

Baseline:
Since 2011, 301 dental providers have attended VDH sponsored dentist CE courses regarding the dental care of CSHCN, including 181 dentists and 120 auxiliary staff members. As of September 2015, there were 2,548 dentists with active accounts on the VDH Dental Health Program online directory of dentists willing to treat CSHCN or very young children. As of August 2014, there were approximately 7,000 dentists licensed in Virginia.

Data Source:

Program data is obtained directly from education attendance sheet tallies, dental provider surveys after course participation and the online directory database.

State Health Problem:

Health Burden:
In 2011, the Virginia Health Promotion for People with Disabilities Project of the Virginia Partnership for People with Disabilities, developed *Health Status of Virginians with Disabilities 2007–2009, An Analysis of Behavioral Risk Factor Surveillance System (BRFSS) Data*. This report is not specific to CSHCN. However, it does recognize the health disparities of people with disabilities. "Compared to people without disabilities, those with disabilities either demonstrated a statistically lower frequency of positive health practices or reported more health disparities related to the following areas ...including visiting a dentist, getting teeth professionally cleaned routinely, and having teeth extracted due to gum disease or tooth decay." http://www.hppd.vcu.edu/documents/2012/VirginiaBRFSSReportFINAL1-25-12mu.pdf

According to the policy brief, Promoting the Oral Health of Children with Special Health Care Needs—In Support of the National Agenda, "the National Agenda for Children with Special Health Care Needs (CSHCN) calls for the development of systems of care that are family centered, community based, coordinated, and culturally competent. This agenda addresses a long-term national goal articulated in Healthy People 2010: National Health Promotion and Disease Prevention Objectives. That goal is to increase the proportion of states and territories that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.” The basis of these service systems lies in education and awareness to fuel the desire for effective change.
http://www.mchoralhealth.org/PDFs/CSHCNPolicyBrief.pdf Healthy People 2020 also includes objectives related to oral health in three key ways related to this program: dental caries experience, use of oral health care system and dental services for low income children and adolescents.

Target Population:
Number: 296,668
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban

Primarily Low Income: Yes

Disparate Population:
Number: 296,668
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: 2009/10 National Survey of Children with Special Health Care Needs information on the Data Resource Center on Child and Adolescent Health, the estimated number of CSHCN in Virginia is 296,668.

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: 1. “Promising State Strategies to Improve the Oral Health of CYSHCN”, 2011 AMCHP and Family Voices National Conference; http://www.astdd.org/docs/cshcn-promisingstatestrategies-2-vodica-blazer-2-13-2011.pdf Report on promising state practices to improve access to dental care in Virginia, Kansas, Wisconsin and Washington. Virginia is the only state that has provided dentist training as well as the maintenance of an online provider directory of dentists willing to treat CSHCN. Washington State has a similar provider directory. Kansas and Wisconsin have both provided dentist trainings.
2. National Maternal and Child Oral Health Policy Center, August 2011 Issue Brief regarding dental professional training: The Affordable Care Act (ACA) supports numerous programs for training new and established dental practitioners in addition to a loan repayment program for the faculty that educate these professionals. http://nmcohpc.net/resources/CSHCN%20Brief.pdf
3. According to the policy brief, Promoting the Oral Health of Children with Special Health Care Needs—In Support of the National Agenda, "the National Agenda for Children with Special Health Care Needs (CSHCN) calls for the development of systems of care that are family centered, community based, coordinated, and culturally competent. This agenda addresses a long-term national goal articulated in Healthy People 2010: National Health Promotion and Disease Prevention Objectives. That goal is to increase the proportion of states and territories that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.” The basis of these service systems lies in education and awareness to fuel the desire for effective change.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $59,104
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Complete contracts and select training venues

Between 10/2015 and 09/2016, Dental Health Program staff will establish **1** contract with the Virginia Dental Association Foundation (VDAF) and select training venues for up to four, two-day dental provider continuing education (CE) courses regarding the dental treatment of CSHCN.

Annual Activities:

1. Approve contracts

Between 10/2015 and 09/2016, Dental Health Program staff will submit a sole source contract between VDH and VDAF for VDH approval, review and signature by VDAF.

2. Contract with speaker/instructor

Between 10/2015 and 09/2016, Dental Health Program staff will arrange for VDAF contract negotiations and finalization of the contract with the speaker/instructor for the courses.

3. Secure training venue

Between 10/2015 and 09/2016, Dental Health Program staff will contact potential sites for the courses, meet with them and arrange for VDAF negotiations and finalization of the contracts with the venues, including the final date set at each location.

4. Contract with instructors

Between 10/2015 and 09/2016, Dental Health Program staff will arrange for VDAF contract negotiations and finalization of the contract with VCU for the utilization of pediatric dental residents as assistant clinical instructors for the courses.

5. Confirm training dates

Between 10/2015 and 09/2016, Dental Health Program staff will confirm final dates with the course venues, speaker, VCU residents and all other support personnel.

Objective 2:

2. Complete mailing

Between 10/2015 and 09/2016, Dental Health Program staff will conduct **1** mailing to 750 licensed dentists in the regions of the planned courses that will include upcoming course information and a request to add dentists to the VDH Dental Health Program online directory of providers for CSHCN or update active accounts with the dentists' most current information.

Annual Activities:

1. Approve letter

Between 10/2015 and 09/2016, Dental Health Program staff will prepare the letter for final review and approval by VDH administration.

2. Prepare mailing

Between 10/2015 and 09/2016, Dental Health Program staff will obtain most the recent database of licensed dentists in the Commonwealth of Virginia; identify the dentists in the target regional areas for each course; and prepare labels and envelopes for mailing.

3. Complete course registrations

Between 10/2015 and 09/2016, Dental Health Program staff will mail letters regarding upcoming courses; receive course registrations; and respond to online directory changes and new submissions, as needed.

Objective 3:

3. Complete trainings

Between 10/2015 and 09/2016, Dental program staff will conduct **4** dental provider CE courses regarding the dental care of CSHCN.

Annual Activities:

1. Facilitate courses

Between 10/2015 and 09/2016, Dental Health Program staff will plan, organize, facilitate and complete

each course. This includes finalizing dental provider registrations, CE credit, and advertising for patients for hands-on portion of course.

2. Evaluate course offerings
Between 10/2015 and 09/2016, Dental Health Program staff will evaluate the outcome and evaluations for each course. In addition, staff will compare outcomes with previous course evaluations and make adjustments to course based on those evaluations, if feasible.

Objective 4:
4. Evaluate project
Between 10/2015 and 09/2016, Dental program staff will evaluate **3** project outcomes related to the provider directory, survey and report.

Annual Activities:
1. Update online directories
Between 10/2015 and 09/2016, Dental Health Program staff will update and maintain the VDH Dental Health Program online directory of providers for CSHCN to determine if more dentists added information to the directory because of the mailing and/or participation in the courses.

2. Conduct follow-up survey
Between 10/2015 and 09/2016, Dental Health Program staff will prepare a follow-up questionnaire/survey to be sent to dentist participants 4-6 months following the completion of the CE course to determine effect of participation on their existing dental practice, especially the effect on their dental treatment of CSHCN, if any.

3. Prepare report
Between 10/2015 and 09/2016, Dental Health Program staff will prepare a final report based on available totals from the project and an assessment of any notable changes to the baseline data.

State Program Title: Prescription Drug Prevention Program

State Program Strategy:

Program Goal:
The goal of the Prescription Drug Prevention Program is to reduce drug related poisoning deaths throughout the life span.

Program Health Priority:
Taking someone else's prescription medication, taking a prescription in a manner that was not as prescribed, or taking a medication for reasons other than prescribed all constitute nonmedical use of prescription drugs. Using a medication in ways other than prescribed can potentially lead to a variety of adverse health effects, including overdose and addiction. Virginia has seen an increase in the number of deaths related to drug/poisoning that replicates the trends seen at the national level. To address the alarming rise in opioid related overdose deaths and the problem of opioid addiction in the Commonwealth of Virginia, Governor McAuliffe signed Executive Order 29 creating the Governor's Task Force on Prescription Drug and Heroin Abuse. The initiative is a key component of "A Healthy Virginia", the Governor's 10-part plan to improve the health of Virginia's most vulnerable citizens. The Task Force was directed to provide a range of policy recommendations, including how to raise public awareness about the misuse of prescription painkillers, train healthcare providers on best practices for pain management, identify treatment options and alternatives to incarceration for people with addiction, and promote the safe storage and disposal of prescription drugs.

The Injury and Violence Prevention Program has taken a lead role in initial primary prevention strategies targeted at improving clinical practices among prescribers, dispensers, and clinical support staff, maximizing the use of the Prescription Drug Monitoring Program and ensuring a competent workforce across the Commonwealth through education and training of a broad spectrum of prescribers and dispensers of controlled substances.

Primary Strategic Partners:
In addition to collaborating with relevant programs in the VDH Offices of Family Health Services, and the Chief Medical Examiner, the Injury and Violence Prevention Program partners with a variety of organizations and agencies at the state and local levels. These include but are not limited to drug free organizations, Safe Kids coalitions, Red Cross chapters, schools, health systems, Poison Control Centers, Virginia Association of Independent Schools, Virginia Chapter of the American Academy of Pediatrics, Virginia Association of School Nurses, Departments of Behavioral Health and Developmental Services and Education.

Evaluation Methodology:
All funded projects will require an evaluation plan following the RE-AIM framework to include, where applicable, the systematic measurement of: the number of participants in training events and the level of exposure for awareness activities (Reach); the impact of trainings and educational sessions on behavioral change and changes in the rates of available Virginia injury data (Efficacy); the number of new partnerships and/or policies developed to support implementation (Adoption); fidelity to best practices at the project level (Implementation); and the extent to which the program becomes institutionalized or part of the routine organizational practice (Maintenance). Outcomes of awareness and training activities will be assessed through tracking of activities; monitoring of audience exposures to information provided; and behavior change that results from activities. In addition, data on the type and number of distributed resources will be collected.

State Program Setting:

Community health center, Local health department, Medical or clinical site, Schools or school district

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Vanessa Walker Harris
Position Title: DPHP Director
State-Level: 0% Local: 0% Other: 5% Total: 5%
Position Name: Heather Board
Position Title: IVT&P Prevention Programs Manager
State-Level: 15% Local: 0% Other: 0% Total: 15%
Position Name: Lisa Wooten
Position Title: Injury Prevention Program Supervisor
State-Level: 25% Local: 0% Other: 0% Total: 25%
Position Name: JoAnn Wells
Position Title: Injury Prevention Program Coordinator
State-Level: 0% Local: 45% Other: 0% Total: 45%
Position Name: Jennifer Schmid
Position Title: Injury & Violence Prevention Program Support
State-Level: 0% Local: 0% Other: 20% Total: 20%

Total Number of Positions Funded: 5
Total FTEs Funded: 1.10

National Health Objective: HO IVP-9 Poisoning Deaths

State Health Objective(s):

Between 10/2015 and 09/2016, the Prescription Drug Prevention Program will prevent an increase in poisoning deaths by maintaining the 2012 death rate of 10.2 per 100,000 until 2020.

Baseline:
There were 10.2 deaths per 100,000 in 2012.

Data Source:
Vital Records

State Health Problem:

Health Burden:
Prescription drug misuse and abuse is a well-documented public health issue that has been growing over the past several years. The Centers for Disease Control and Prevention (CDC) reports that emergency department visits for prescription painkiller abuse or misuse have doubled in the past five years to nearly half a million with about 12 million American teens and adults reporting have used prescription painkillers to get “high” or for other nonmedical reasons. The most commonly abused types of prescription drugs are opioids, benzodiazepines and amphetamine-like drugs. The CDC estimates that nonmedical use of prescription painkillers costs more than $72.5 billion each year in direct health care costs.

Prescription drug abuse is a public health problem across the Commonwealth. Virginia has seen increases in the number of deaths caused by poisonings and drug overdoses that replicate trends seen at the national level. According to Virginia vital records data, the rate of death due to poisoning increased by 13.2% from 9.2 per 100,000 in 2010 to 10.41 per 100,000 in 2013. Drug overdoses comprised the largest group of poisoning cases, and the drug overdose death rate increased from 8.2 per 100,000 in 2010 to 9.36 per 100,000 in 2013, a 14.1% increase. In recent years, the rate of death by motor vehicle traffic (a leading cause of injury death) has at times been eclipsed by the rate of death by drug overdose. The

majority of drug overdose deaths in 2013 occurred among males (62.1%), those between the ages of 25 and 54 (73.3%), and non-Hispanic whites (84.7%). The overwhelming majority of drug overdoses were attributed to unintentional causes (79.4% in 2013).

In some portions of the state, particularly the Southwestern and Northwestern regions (typically considered parts of Appalachia), rates are much higher and the problem of drug overdose is substantial. The crude average annual drug overdose death rate for 2011-2013 in one Virginia health district in the Southwestern region was 37.4 per 100,000 (over three times the statewide rate for 2013), exceeding the West Virginia crude rate for 2013. An additional district in the Southwest had a crude average annual drug overdose death rate in the same period of 21.8 (over twice the statewide rate), ranking it just higher than the crude rates for Ohio, Oklahoma or Utah in 2013. Two other districts in the Southwestern region had crude average annual rates for the same period of between 19.4 and 19.7, rates that were nearly twice the state rate and which rank them higher than Tennessee's crude rate for 2013. Prescription opiates accounted for 51% of recorded drug overdoses in 2013. Among those who died with a prescription opiate as a contributing cause in 2013, 87.6% were non-Hispanic white, between the ages of 25 and 54 (75.1%) and male (54.3%). Given the suspected links between the use of prescription opiates and heroin, it is important to note that Virginia's rate of death by heroin overdose increased 396% from 2010 to 2013. The proposed rationale is that as prescription drugs (especially opioids) become harder to acquire illegally, users are turning to heroin which acts on the same brain receptors.

Target Population:
Number: 7,882,590
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 7,882,590
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Virginia Governor's Task Force on Prescription Drug and Heroin Abuse Recommendations
Association of State and Territorial Health Officials "Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care"
National Partnership for Drug Free America; Smart Moves, Smart Choices (National Association of School Nurses)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $151,969

Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

1. Assure a competent workforce

Between 10/2015 and 09/2016, VDH will develop **1** online training for community health center healthcare providers as part of an online training series to increase best practices in controlled substance prescription prescribing and dispensing, responsible case management, and participation in the Prescription Monitoring Program as measured by a follow up assessment of providers completing the online training to measure enacted practice and policy changes reflective of best practices.

Annual Activities:

1. Provide training and education

Between 10/2015 and 09/2016, VDH will develop a module for community health center healthcare providers to be added to the special population modules. This module will be developed to tailor comprehensive controlled substance services for the transient population focused on removing persistent barriers of care encountered by community health centers and meeting unique cultural and health needs of clients.

2. Collect and report process and outcome data

Between 10/2015 and 09/2016, training participants will be contacted three months post-training to collect outcome data related to changes in practice and policy changes reflective of best practice.

Objective 2:

2. Assure a competent workforce

Between 10/2015 and 09/2016, VDH will develop **1** online training for clinical nurses and dental hygienist professionals practicing in medical/dental offices to increase best practices in delegate support of the primary healthcare provider in implementing best practices in controlled substance prescription prescribing and dispensing, responsible case management, and participation in the Prescription Monitoring Program as measured by a follow up assessment of professionals completing the online training to measure an increase in enacted practice and policy changes reflective of best practices.

Annual Activities:

1. Provide training and education

Between 10/2015 and 09/2016, VDH will develop a module for clinical for nurses and dental hygienist professionals in medical/dental offices to be added to the special population modules to increase best practices in support of the primary healthcare provider.

2. Collect and report process and outcome data

Between 10/2015 and 09/2016, training participants will be contacted three months post-training to collect outcome data related to changes in practice and policy changes reflective of best practice.

State Program Title: Sexual Assault Intervention and Education Program

State Program Strategy:

Program Goal:
The goal of the Sexual Assault Intervention and Education program is to increase and improve services to victims of sexual assault.

Program Health Priority:
Rape and sexual assault are public health problems in Virginia. In 2014, there were 4,668 forcible sex offenses reported to the Virginia police. (Source: Crime in Virginia, Virginia State Police, 2015). In Virginia, the lifetime prevalence of sexual violence other than rape is estimated to be 42.0% for women and 20.9% for men. The life time prevalence of rape for women in Virginia is estimated to be 11.4% (Source: The National Intimate Partner and Sexual Violence Survey, 2010). In cases of sexual assault, however, the victim is often hesitant to report the crime to law enforcement officials. It has been estimated that only 34% of rapes and sexual assaults are reported to police, this is a 7% decrease since 2007 when the estimated sexual assaults reported to police was 41% ("Criminal Victimization, 2014", U.S. Department of Justice, Office of Justice Programs, August 2015).

This violence also has short and long-term health related consequences. The 2010 National Intimate Partner and Sexual Violence Survey reported “women who had experienced rape or stalking by any perpetrator or physical violence by an intimate partner in their lifetime were more likely than women who did not experience these forms of violence to report having asthma, diabetes, and irritable bowel syndrome.” The survey also reported that “men and women who experienced these forms of violence were more likely to report frequent headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical health and poor mental health than men and women who did not experience these forms of violence.”

Primary Strategic Partnerships:
The Virginia Department of Health Injury and Violence Prevention Program will partner with the Virginia Department of Health Family Planning Program, the Virginia Department of Criminal Justice Services, and contract with the Virginia Sexual and Domestic Violence Action Alliance (the Action Alliance) to provide statewide coordination of sexual assault advocacy, data collection on victim services and outcomes, technical assistance, and training and other support to local sexual assault crisis centers and other professionals working to improve the community response to sexual assault.

Evaluation Methodology:
The VDH PHHS Sexual Assault Set Aside Program will use training evaluations developed and tested by Futures Without Violence to evaluate Project Connect trainings. Training participants will complete pre-, post- and follow-up evaluation surveys to obtain data on effectiveness of trainers and changes in providers’ screening and referral behaviors.

The Action Alliance will submit quarterly reports to VDH to provide qualitative data on collaboration, policy and systems change as well as impact at the local level. Follow up survey information on Community College implementation of best practices for sexual violence prevention will also be included the Action Alliance’s reporting.

State Program Setting:
Local health department, Rape crisis center, University or college, Other: State sexual assault coalition

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Robert Franklin
Position Title: Sexual and Domestic Violence Coordinator
State-Level: 20% Local: 5% Other: 0% Total: 25%
Position Name: Heather Board
Position Title: IV&T Prevention Programs Manager
State-Level: 5% Local: 0% Other: 0% Total: 5%
Position Name: Anya Shaffer
Position Title: Violence & Suicide Prevention Program Coordinator
State-Level: 5% Local: 0% Other: 0% Total: 5%

Total Number of Positions Funded: 3
Total FTEs Funded: 0.35

National Health Objective: HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 10/2014 and 09/2020, VDH will decrease the lifetime prevalence of rape among women by any perpetrator by a 3% decrease from the 2010 baseline of 11.4% to 11.1%.

Between 10/2014 and 09/2020, VDH will decrease the lifetime prevalence of rape, physical violence or stalking among women by an intimate partner by a 3% decrease from the 2010 baseline of 31.3% to 30.4%.

Baseline:

The lifetime prevalence of rape was 11.4% in 2010.
The lifetime prevalence of rape, physical violence was 31.3% in 2010.

Data Source:
National Intimate Partner and Sexual Violence Survey

State Health Problem:

Health Burden:
In 2014, there were 4,668 forcible sex offenses reported to the Virginia police (Crime in Virginia, Virginia State Police, 2015). In Virginia, the lifetime prevalence of sexual violence other than rape is estimated to be 42.0% for women and 20.9% for men. The life time prevalence of rape for women in Virginia is estimated to be 11.4% (Source: The National Intimate Partner and Sexual Violence Survey, 2010). In cases of sexual assault, however, the victim is often hesitant to report the crime to law enforcement officials. It has been estimated that only 34% of rapes and sexual assaults are reported to police, this is a 7% decrease since 2007 when the estimated sexual assaults reported to police was 41% ("Criminal Victimization, 2014", U.S. Department of Justice, Office of Justice Programs, August 2015).

Virginia's sexual assault crisis centers annually provide services to over 7,000 victims of sexual assault. In 2014, sexual assault centers served 5,405 adult victims of sexual assault, and 1,822 child/youth victims (under 18). Rape is the most costly of all crimes to its victims, with total estimated costs at $127 billion a year (excluding the cost of child sexual abuse), with researchers estimating that each rape cost approximately $151,423 (DeLisi, 2010). Associated health care costs are significant. In 2008, violence and abuse constituted up to 37.5% of total health care costs, or up to $750 billion (Dolezal, McCollum, & Callahan, 2009).

Target Population:
Number: 7,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 7,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Crisis center service delivery figures

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Evidence-based programs and guidelines for victim services are available from the Institute of Medicine, the American College of Obstetricians and Gynecologists and Healthy People 2020.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $178,896
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
1. Assure a competent workforce
Between 10/2015 and 09/2016, the VDH Violence Prevention Program will conduct **7** trainings regarding the provision of comprehensive services and the prevention of sexual assault.

Annual Activities:
1. Host four regional trainings
Between 10/2015 and 09/2016, VDH will continue to utilize the Project Connect curriculum and materials for family planning providers and home visitors to increase their knowledge on domestic and sexual violence, including reproductive coercion, and enhance screening skills. VDH will host four regional trainings using the Project Connect curriculum in collaboration with VDH Family Planning Staff.

2. Contract with coalition for training
Between 10/2015 and 09/2016, utilizing the Project Connect curriculum and materials for domestic violence advocates, VDH will contract with the state coalition to coordinate two in-person, six hour trainings to staff in contracted sexual/domestic violence agencies to increase their knowledge on domestic and sexual violence, including reproductive coercion, and enhance screening skills.

3. Provide training to HIV Prevention staff
Between 10/2015 and 09/2016, the VDH Violence Prevention Program, in collaboration with the VDH Division of Disease Prevention, will adapt the Project Connect Reproductive Coercion materials to provide one training to HIV Prevention staff on the screen of reproductive coercion.

4. Complete evaluation surveys
Between 10/2015 and 09/2016, training participants will complete pre-, post- and follow-up evaluation surveys to obtain data on effectiveness of training and materials.

Objective 2:
2. Provide state level leadership
Between 10/2015 and 09/2016, the VDH Violence Prevention Program will develop **1** work plan to address current trends and needs related to reproductive and sexual coercion and will provide state level leadership on the implementation of reproductive coercion screening.

Annual Activities:
1. Develop purpose and mission
Between 10/2015 and 09/2016, VDH will lead the development of a revised purpose and mission for the Project Connect Advisory Council to guide future activities.

2. Coordinate assessment
Between 10/2015 and 09/2016, VDH will coordinate an assessment of Project Connect training implementation among currently trained VDH Family Planning staff and home visitors to evaluate the implementation of IPV screening and referral to local resources.

3. Coordinate revision of materials
Between 10/2015 and 09/2016, VDH will coordinate the review and revision of Project Connect training materials to support refresher trainings among VDH Family Planning staff and home visitors.

Objective 3:
3. Provide technical assistance
Between 10/2015 and 09/2016, VDH will distribute at least 30,000 printed resources and provide 100 hours of technical assistance on sexual assault, including reproductive coercion, to **all interested** healthcare providers, advocates and allied professionals.

Annual Activities:
1. Print and disseminate resources
Between 10/2015 and 09/2016, VDH will print and disseminate at least at least 30,000 resources on sexual assault, including reproductive coercion, to healthcare providers, advocates and allied professionals.

2. Coordinate training assessment
Between 10/2015 and 09/2016, VDH will coordinate an assessment of Project Connect training implementation among currently trained VDH Family Planning staff and home visitors to evaluate the use of the printed safety cards.

3. Contract with the coalition for technical assistance
Between 10/2015 and 09/2016, VDH will contract with the state sexual violence coalition to provide resources and technical assistance to allied professionals on reproductive and sexual coercion screening,

assessment and collaboration. Technical assistance provided will be documented.

4. Contract with coalition for website resources
Between 10/2015 and 09/2016, VDH will contract with the state sexual violence coalition to post resources on the statewide Community Defined Solutions website related to reproductive health, sexual and reproductive coercion, and tools for assessment. In addition, related resources will be disseminated via Resonance, an electronic newsletter for advocates in Virginia. Online “usefulness” survey data, number of resources viewed and downloaded will be report.

Objective 4:
4. Build capacity of agencies
Between 10/2015 and 09/2016, VDH will develop **4** local sexual/domestic violence agencies' capacity to implement comprehensive reproductive and sexual coercion screening and assessment.

Annual Activities:
1. Contract with coalition for assessments
Between 10/2015 and 09/2016, VDH will contract with the state sexual violence coalition to train **4** local sexual/domestic violence agencies to implement comprehensive reproductive and sexual coercion screening and assessment.

2. Contract with coalition to review reports
Between 10/2015 and 09/2016, VDH will contract with the state sexual violence coalition to review quarterly reports from contracted sexual/domestic violence agencies measure the implementation of comprehensive reproductive and sexual coercion screening and assessment.

3. Contract with coalition for technical assistance
Between 10/2015 and 09/2016, VDH will contract with the state sexual violence coalition to provide technical assistance to contracted sexual/domestic violence agencies to ensure implementation of the Project Connect screening and assessment at shelter intake. Technical assistance provided will be documented.

Objective 5:
5. Host a policy summit
Between 10/2015 and 09/2016, VDH will conduct **1** one-day community college summit to increase the use of best practices for college response, adjudication, policy and prevention related to sexual violence and sexual violence prevention.

Annual Activities:
1. Contract with coalition to provide training
Between 10/2015 and 09/2016, VDH will contract with the state sexual assault coalition to collaborate with the Department of Criminal Justice Services, and the Virginia Community College System to provide training in order to increase the use of best practices for college response, adjudication, policy and prevention related to sexual violence and sexual violence prevention.

2. Complete evaluation
Between 10/2015 and 09/2016, VDH will complete a post conference evaluation and three month follow to assess the effectiveness of training and the schools' implementation of best practices.

Objective 6:
6. Increase use of revised form
Between 10/2015 and 09/2016, VDH will increase the percent of local domestic and sexual violence programs implementing prevention programming that will use the revised VAData Community Engagement Form from 50% to **70%**.

Annual Activities:
1. Revise VAData Community Engagement Form

Between 10/2015 and 09/2016, VDH will work with the state sexual assault coalition to review and propose changes to the VAData Community Engagement Form in order to improve the collection of sexual violence prevention data and outcomes from local domestic and sexual violence programs across the state.

2. Provide technical assistance

Between 10/2015 and 09/2016, VDH will contract with the state sexual assault coalition to promote and provide technical assistance related to the use of the VAData Community Engagement Form by local domestic and sexual violence programs.

State Program Title: Traumatic Brain Injury Prevention Program

State Program Strategy:

Program Goal:
The program goal is to prevent traumatic brain injuries among youth and to increase the diagnosis and proper management of concussions to support full recovery and to decrease injury severity.

Program Health Priority:
The CDC identifies traumatic brain injury (TBI) as a leading public health issue throughout the U.S.. Across the lifespan, there are many different mechanisms of injury which can result in TBI. The Traumatic Brain Injury Prevention Program targets prevention efforts on school age children given the known health and development implications of injury to the developing brain. Specific efforts are focused on preventing injuries related to sports and recreational activities such as bicycling.

Nationally between 1966 and 2009, the number of children who bicycle or walk to school has decreased by 75%. However, recent efforts to address obesity, especially childhood obesity, and healthy living focus on increasing community-level walking and bicycling initiatives in Virginia as effective intervention strategies. The challenge is that many public health efforts to promote physical activity seldom address the numerous available strategies to prevent related injuries and fatalities.

As with most types of unintentional injuries, bicycle related injuries and fatalities are preventable. Changes in behavior, the use of proven safety devices, environmental improvements and policy enhancements all support the prevention of injuries. The most effective prevention strategies focus on behavior change to make the largest impact.

Primary Strategic Partners:
In addition to collaborating with relevant programs in the VDH Office of Family Health Services, the Injury and Violence Prevention Program partners with a variety of organizations and agencies at the state and local levels. These include but are not limited to Safe Kids coalitions, schools, health systems, Virginia High School League, Virginia Association of Independent Schools, Virginia Chapter of the American Academy of Pediatrics, Bike Walk Virginia, VA Association of Health, Physical Education, Recreation and Dance, VA Recreation and Park Society, VA Safe Routes to School Network, Brain Injury Association of VA, and the Virginia Departments of Education, Conservation and Recreation, Motor Vehicles and Transportation.

Evaluation Methodology:
All funded projects will require an evaluation plan following the RE-AIM framework to include, where applicable, the systematic measurement of the following: the number of participants in training events and the level of exposure for awareness activities (Reach); the impact of trainings and educational sessions on behavioral change and changes in the rates of available Virginia injury data (Efficacy); the number of new partnerships and/or policies developed to support implementation (Adoption); fidelity to best practices at the project level (Implementation); and the extent to which the program becomes institutionalized or part of the routine organizational practice (Maintenance). Outcomes of awareness and training activities will be assessed through tracking of activities; monitoring of audience exposures to information provided; and behavior change that results from activities. In addition, data on the type and number of distributed resources will be collected.

State Program Setting:
Medical or clinical site, Schools or school district, Senior residence or center

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Vanessa Walker Harris
Position Title: DPHP Director
State-Level: 0% Local: 0% Other: 3% Total: 3%
Position Name: Heather Board
Position Title: IV&T Prevention Program Manager
State-Level: 15% Local: 0% Other: 0% Total: 15%
Position Name: Lisa Wooten
Position Title: Injury Prevention Program Supervisor
State-Level: 15% Local: 0% Other: 0% Total: 15%
Position Name: JoAnn Wells
Position Title: Injury Prevention Program Coordinator
State-Level: 0% Local: 25% Other: 0% Total: 25%
Position Name: Jennifer Schmid
Position Title: Injury & Violence Prevention Program Support
State-Level: 0% Local: 0% Other: 15% Total: 15%

Total Number of Positions Funded: 5
Total FTEs Funded: 0.73

National Health Objective: HO IVP-2 Traumatic Brain Injury

State Health Objective(s):

Between 10/2014 and 09/2020, VDH will reduce the rate of fatal traumatic brain injuries by 3% from 18.3 per 100,000 to 17.8 per 100,000.

VDH will reduce the rate of traumatic brain injury hospitalizations by 3% from 58.4 per 100,000 to 56.6 per 100,000.

Baseline:

The rate of fatal traumatic brain injuries was 18.3 per 100,00 in 2012.

The rate of traumatic brain injury hospitalizations was 58.4 per 100,000 in 2012.

Data Source:
Vital Records

Virginia Health Information

State Health Problem:

Health Burden:
Virginia had a 2012 traumatic brain injury hospitalization rate of 22.5 per 100,000 and a death rate of 4.7 per 100,000 among those 5-18 years of age.

In Virginia during 2012, approximately 45% of all bicycle crashes were the result of rider errors such as failure to yield, ignoring traffic signals, improper turning etc. A critical focus of bicycle behavior change needs to target increasing proper bicycle helmet use. Most helmet use activities target young children because this is an audience who can be more easily influenced than other age groups. It is important to start early with behavior change to encourage healthy, safe behaviors to become lifestyle norms. Unfortunately, bicycle helmet use tends to decline as age increases, making young adults more

vulnerable to head injuries as they grow older. The Virginia Youth Survey found 85% of Virginia 12th graders rarely or never wore a helmet during bicycle use.

Target Population:
Number: 1,279,773
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,279,773
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Highway Traffic Safety Administration Cycling Skills Clinic Guide
U.S. Consumer Product Safety Commission Public Playground Safety Handbook
National Program for Playground Safety SAFE principles
National Highway Traffic Safety Administration and American Academy of Pediatric safe transportation for children guidelines.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $108,733
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

1. Assure a competent workforce

Between 10/2015 and 09/2016, VDH will conduct **4** Bike Smart Basics trainings for health and physical education teachers to support the implementation of bicycle safety units of instruction.

Annual Activities:

1. Provide training and education
Between 10/2015 and 09/2016, the Injury and Violence Prevention Program will partner with the Virginia Department of Education to conduct four regional trainings for health and physical education teachers.

2. Provide technical assistance
Between 10/2015 and 09/2016, VDH will provide technical assistance to organizations to ensure the program is executed with fidelity and integrity.

3. Collect and report process and outcome data
Between 10/2015 and 09/2016, VDH will collect process data at the time of each training to determine current school policies. Training participants will then be contacted 3-6 months post-training to collect outcome data related to changes in policy.

Objective 2:
2. Publish and distribute resources
Between 10/2015 and 09/2016, VDH will distribute the Emergency Action Planning Guide for after-school practices and events with detailed information on concussion prevention and management for the youth athlete to **100%** of public high schools and those private/independent schools sanctioned by the Virginia High School League.

Annual Activities:
1. Provide technical assistance
Between 10/2015 and 09/2016, in collaboration with the Virginia High School League and Virginia Athletic Trainer's Association, the Injury and Violence Prevention Program will align the *Emergency Action Planning Guide for after-school practices and events* (developed by the Minnesota State High School League) with the Virginia Student Protection Act addressing concussions in the youth athlete. This document will be distributed to all Virginia public high schools.

2. Collect and report process and outcome data
Between 10/2015 and 09/2016, schools will be contacted six months post-distribution to collect outcome data related to changes in policy and incorporation of best practices as outlined in the document.